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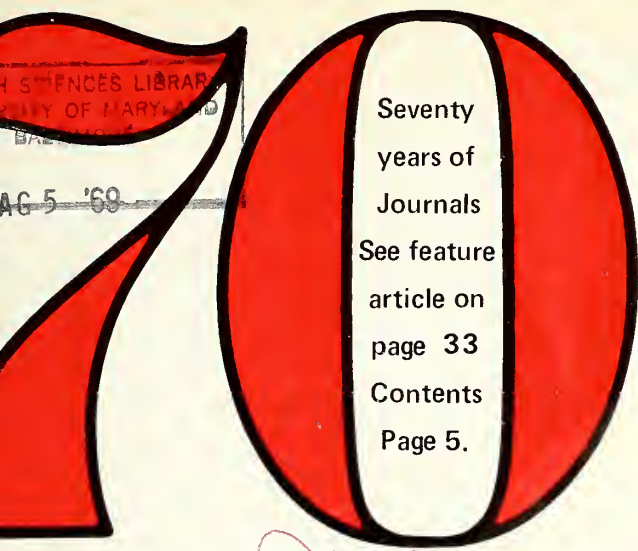




July, 1969 / Vol. 136, No. 1

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# I M J

*Illinois Medical Journal*

OFFICIAL JOURNAL OF THE ILLINOIS STATE MEDICAL SOCIETY

# I M J

# I M J



# Flagyl<sup>®</sup>

brand of

## metronidazole

# simplifies

# vaginitis

# therapy

The effectiveness of Flagyl in *Trichomonas vaginalis* vaginitis has been so constant that use of less effective agents would seem to invite unnecessary failures. ■ The simplicity, completeness and persistence of cures with Flagyl qualify it as the logical first therapeutic choice in trichomonal infections.

**simple**  
**complete**  
**lasting**

Ten-day treatment with Flagyl oral tablets has replaced a multitude of untidy douches, powders, creams and jellies.

Flagyl is the only medication available that is able to reach all the crypts, glands and cavities of the female urogenital system as well as as reservoirs of reinfection in male trichomonas carriers.

Flagyl eradicates resistant, deep-seated invasions of *Trichomonas vaginalis* and consistently produces cure rates above 90 per cent and often as high as 100 per cent in large series of patients. When the diagnosis is positive, Flagyl is positive.

**Indications:** For the treatment of trichomoniasis in both male and female patients and the sexual partners of patients with a recurrence of the infection provided trichomonads have been demonstrated by wet smear or culture. ■ **Contraindications:** Evidence of or a history of blood dyscrasia, in patients with active organic disease of the central nervous system, and the first trimester of pregnancy. ■ **Warnings:** Use with discretion during the second and third trimesters of pregnancy and restrict to patients not cured by topical measures. Flagyl is secreted in the breast milk of nursing mothers; it is not known whether this can be injurious to the newborn. ■ **Precautions:** Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur. ■ **Adverse Reactions:** Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia*, exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified. ■ **Dosage and Administration:** *In the Female.* One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used, one 500-mg. insert is placed high in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment.* Do not use the vaginal inserts as the sole form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner. ■ **Dosage Forms:** Oral tablets.....250 mg. Vaginal inserts.....500 mg.



# BLUE SHIELD REPORT



## FOR *Illinois Physicians*

PUBLISHED MONTHLY BY: BLUE SHIELD PLAN OF ILLINOIS MEDICAL SERVICE • 222 NORTH DEARBORN AVENUE • CHICAGO, ILLINOIS 60601

Vol. 3, No. 7

July, 1969

### Blue Shield Now in England

The British United Provident Association (BUPA), a thriving private health care financing organization in Great Britain, has become an affiliate member of the National Association of Blue Shield Plans.

Now for the first time the Blue Shield symbol is extended beyond the Atlantic Ocean.

Even with England's comprehensive National Health Service for all people almost totally financed by government tax funds, there are over 2,000,000 British citizens today who have chosen to pay extra for the convenience of treatment by private physicians in private hospitals and offices. This is done through a variety of prepayment organizations such as the BUPA, which is the largest and has 1,500,000 members.

The British organization has experienced membership growth nearly twenty times what it was when it was started in 1948 with 80,000 members. In 1968, BUPA had subscription income of 11½ million pounds (\$27 million). The organization has built a chain of hospitals to serve its subscribers. The hospitals were financed through BUPA's investment program and the support of members in local communities.

According to Eric D. Roberts, General Manager of BUPA, "Private medicine will continue to grow in Great Britain because many people are attracted by its advantages.

"They like the freedom of choice both of the doctor and the place where the treatment is received, the privacy enjoyed, the absence of formal visiting hours and the speed of treatment, all inhibiting factors under the national system."

Non-profit medical care plans located outside the United States may become eligible for affiliation with the National Association of Blue Shield Plans, provided such plans comply with Blue Shield's standards for affiliation. The only other foreign affiliate members of NABSP are located in the Canadian provinces.

The affiliation of the British United Provident Association with the National Association of Blue Shield Plans does not mean that a Blue Shield member visiting Britain will receive benefits from BUPA. The Blue Shield Plan of Illinois Medical Service has always provided its members with benefits for covered medical services rendered by private physicians in any country.

(This is not an advertisement)

### New Blue Cross-Blue Shield for Non-Group Members

Illinois Blue Cross and Blue Shield have developed an outstanding new plan for members not in a group that provides group benefits in terms of the scope of the program. The Health Services Plan became effective July 1 for present members and other individuals who chose to take advantage of this new and improved protection.

The new Health Services Plan will raise the level of our present non-group coverage for existing basic services, while adding benefits for several new categories of hospital and medical services, including out-of-hospital diagnostic services never offered before to non-group members. In most cases, the Health Services Plan pays \$80 of every \$100 that has to be spent for covered hospital and doctor bills.

Out-of-hospital diagnostic care makes an important contribution toward the early recognition of disease. Blue Cross and Blue Shield will pay 80 percent of out-patient diagnostic tests when these tests are related to a definite complaint. X-Ray and laboratory tests are included whether they are performed in the out-patient department of the hospital or in the doctor's office. Tests performed in a laboratory or clinic are also included when ordered by the individual's doctor.

The Health Services Plan pays 80 percent of X-Ray services both in and out of the hospital.

Unmarried children under family contracts are eligible for benefits until their 23rd birthday, compared to the 19-year-old limit under the present program.

Between 80 to 85 percent of our non-group subscribers to whom we have made the offering have indicated they want the new Health Services Plan. This bears out our contention that people desire and are willing to pay for quality health care programs.

The Health Services Plan which provides the finest protection Blue Cross and Blue Shield have ever offered to members not in a group, will pay 80% of usual, customary, and reasonable charges for covered services.

## ASK BLUE SHIELD

### • • • ABOUT MEDICARE

**Q** If my Medicare patient has Blue Cross 65 and Blue Shield 65, is it necessary to submit a "Physician's Service Report" as well as a Medicare "Request for Payment" form?

**A** Yes. These are two entirely different insurance coverages. It is necessary to complete a Medicare "Request for Payment" form and it is also necessary to submit a completed "Physician's Service Report" to Blue Shield for payment.

**Q** When does the deductible "carry-over" rule apply?

**A** A special "carry-over" rule has been established to help the beneficiary who might otherwise need to meet the \$50 deductible twice in a short period. Expenses which apply toward the deductible in October, November, and December of a calendar year can also apply toward the deductible for the following calendar year.

**Q** May gel pads and alternating pressure mattresses be covered as durable medical equipment under the Medicare program?

**A** Yes. Items of equipment such as gel pads and alternating pressure mattresses may be covered when used by a patient who has decubiti or there is medical evidence that the patient is highly susceptible to such ulceration. There must be sufficient medical information submitted to indicate that the items will clearly serve a therapeutic purpose. In addition, a physician must prescribe the use of the item for treatment of the patient's condition and the prescription must specify that the physician will be supervising its use in connection with his course of treatment.

**Q** If I find it necessary to have X-Rays taken in my patient's home, will Medicare make reimbursement?

**A** Yes, provided the Request for Payment form or the itemized bill indicates the physician who ordered the X-Ray as well as the supplier of the X-Ray services if it is someone other than the attending physician. Also, the area X-Rayed must be indicated.

**Q** If I see a patient in a hospital, must I indicate every date I visited the patient in the Request for Payment form or on an itemized bill?

**A** Yes, but your billing may be abbreviated, e.g., "daily hospital visits from February 19, 1969 to March 3, 1969 @ \$\_\_\_\_\_ a day". However, if there is a difference in your fee from one day to another, it must be so indicated.

**Q** If I see a patient in an intensive care unit, should I record the length of time involved in each visit?

**A** Yes. In order to make payment for a claim for intensive care, it is necessary for our Medicare office to know the approximate time you spent with the patient if it is longer than what might be considered a usual ICU visit.

**Q** As a psychiatrist I often have to consult with a member or members of my patient's family. Would my charges for these services be covered under Part B?

**A** In certain types of medical conditions the physician may contact relatives and close associates to obtain background information to assist in diagnosis and treatment of the patient. When a psychiatrist contacts his patient's relatives or associates for this purpose, charges for such services may be paid by Medicare. However, form SSA 1490 should contain a full explanation of the nature of the interview including the relationship of the person interviewed to the patient.

If the Medicare beneficiary is not a hospital inpatient, reimbursement under Part B would be subject to special limitation on payments for physician's services in connection with mental, psychoneurotic and personality disorders.

**Q** Is esophageal speech training covered under Part B of the Medicare program?

**A** Under limited circumstances, it is covered. When provided by or under arrangements made by a home health agency as part of a home health plan for a home bound beneficiary, the esophageal speech training is reimbursable as speech therapy.

Such training is also covered as an out-patient hospital service when furnished under medical supervision in the out-patient department of a participating hospital.

Esophageal speech training is covered when given by a physician or by his employees who assist him in his treatment and whose services are included in the physician's bill.

### Please Help Us

Lately we have received many inquiries from patients who were referred to the Professional Relations Department of Blue Shield by their doctors or their doctors' office assistants.

The Professional Relations Department was established to provide services to professionals and their office assistants and to handle inquiries referred directly to them by the medical profession. We would appreciate your telling your patients to contact either Medicare (661-4252) or Blue Cross-Blue Shield (661-4200) or to write to either Plan at 222 North Dearborn Street, Chicago, Illinois 60601.





Edward W. Cannady, M.D.

# The President's Page

## CONTINUING EDUCATION GETS TOP PRIORITY

**T**here should be no justification for compulsory relicensure of all physicians as proposed by the President's Commission on Health Manpower!

I'm sure we all agree this is unnecessary. But to avoid having such restrictions imposed, I have given top priority to the establishment of a sound continuing education program for ISMS during 1969-70. This is especially significant today when many of us are experiencing difficulty in keeping abreast of the rapid advances in medicine.

### **M.D.'s Have A Duty**

As physicians we have an obligation to participate in a continuing education program . . . both to our patients and for our professional growth. We must ask ourselves: What are my needs? What knowledge must I have? and, What is the most efficient method for obtaining this knowledge?

I believe the Illinois State Medical Society should help answer these questions through the formation of an independent Council on Continuing Medical Education. This council would help identify your educational needs according to your area of clinical interest. It could also develop the types of instruction best suited to the requirements of various physician groups.

### **Take Seminars Downstate**

For example, most scientific seminars are offered only in large urban areas. This makes it difficult for our downstate physi-

cians to attend because, in many instances, it means leaving their communities without medical protection. A Council on Continuing Medical Education should study methods of bringing these scientific seminars closer to the rural physician, thus making it easier for him to attend.

### **ISMS Needs Help**

Of course, the Illinois State Medical Society cannot implement a comprehensive educational program on its own. That is why I propose that the Council on Continuing Medical Education be a separate body consisting of ISMS representatives, specialty societies, the Academy of General Practice, all Illinois medical schools and other interested organizations.

The council should have a full-time staff adequate to identify the needs of Illinois physicians, should study and prepare an overall plan for continuing medical education, and should enlist the services and facilities of various groups in the delivery of these programs.

As for the costs of this program . . . I have been assured that funds could be made available from the Regional Medical Program to finance this continuing medical educational effort. I hope that preliminary implementation of this program can start this fall.

*Edward W. Cannady*



# The longest flagpole sit-down... 211 days 9 hours



# Abstracts Of Board Actions

Meeting May 17-21, 1969—Chicago  
(Meeting daily during the convention)

*These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.*

## REPORTS OF OFFICERS AND TRUSTEES

Various reports received indicated extensive activities in various areas and consideration of many problems and projects since the previous Board meeting.

## INCOME TAX

The Board approved a resolution to be presented to the House of Delegates in support in principle of the governor's proposed income tax.

## MEDICAL SERVICE

An allocation of \$10 of the \$20 dues for AMA-ERF to initiate pilot projects in medically deprived areas and to expand programs to increase medical school enrollment as proposed in a resolution to the House of Delegates was approved by appropriate action of the Board.

## MEDICAL (PEER) REVIEW

The Board considered a joint request from the Department of Public Health and the Department of Public Aid to provide physicians to serve as paid consultants to aid in conducting reviews of nursing home patients as required under Medicaid—to determine the need for further care and the appropriate type of care. A request from Continental Assurance Company for review of the utilization of out-of-hospital physicians services under Part B of Medicare was also considered. The Board accepted the concept of peer review embodied in these requests and authorized appointment of an Ad Hoc Committee to determine how these two requests might be implemented. In acting upon a previous request from Blue Cross-Blue Shield for recommended paid consultants to aid in utilization review, the Board suggested the possible use of ISMS District Prepayment Plans or Grievance Committees.

## HUNGER

ISMS has been asked to testify before the Legislative Advisory Committee to IDPA relative to the adequacy of the nutritional standards on which the IDPA food allowance is based. The Board took a stand on this matter several years ago. The Board reaffirmed its previous position that the nutritional content upon which the IDPA food allowance is based is adequate to meet basic nutritional requirements.

## ESCALATION OF FEES

The Board authorized a letter to be sent by ISMS legal counsel to all specialty groups emphasizing the importance of avoiding group action for escalation of fees by the specialty groups under the usual and customary fee concept.



## COUNCIL AND COMMITTEE STRUCTURE

In approving the report of the Ad Hoc Committee to study the council and committee structure, the Board took action to clarify the relationship and duties of the councils and committees, increased the number of councils from six to eight, and redefined areas of concern. Changes in the Constitution and By-Laws to accomplish these were authorized for presentation to the House of Delegates.

## UNITED MINE WORKERS' PROGRAM

The Board considered a request from the Jackson County Medical Society concerning a new feature of the United Mine Workers' program which allows payment for ambulatory physician services on a restricted and designated basis. A policy was requested to indicate whether it is ethical for a physician to participate in such a program involving a restriction limiting free selection of physician.

In accordance with the policy of dealing with third party groups and funding agencies, all differences of fee adjudication must be settled by either a county, district, or state Prepayment Plans and Organizations Committee. In acting upon this matter, the Board authorized a communication be sent simultaneously to the Jackson County Medical Society and to the UMW indicating this policy.

## DEAN DISCUSSES MEDICAL SCHOOL AFFAIRS

Dr. William Grove, dean of the University of Illinois Medical School, discussed current and projected developments of the U. of I. program. He reviewed sources, ultimate destinations and medical activities of students, plans for increasing physician services in Illinois, curriculum changes, enrollment projections through 1973, the development of downstate clinical centers, and long-range development plans.

## STATE TO REVIEW MENTAL HEALTH PROGRAMS

Mr. John Briggs, acting director, Department of Mental Health, indicated plans to undertake a review of all the Department's clinical programs. He did not, however, specifically identify the formal procedures, nor the professional representation of the evaluating team, for this review. Guidelines for this review procedure are not yet established. The Department is expecting to call upon the medical profession for assistance.

## SAMA AFFAIRS DISCUSSED

The Board received a report from Mr. Bruce Fagel, SAMA treasurer, on the medical student summer job education project. He called attention to specific details of the plan and reviewed various programs for student involvement in medicine. He asked for assistance from ISMS. The request will be further detailed and considered at a later date.

## PHYSICIAN EVALUATION PROPOSED

In acting upon the request of the Advisory Committee to IDPA, the Board requested that IDPA make an evaluation of the practices of all Illinois physicians receiving \$25,000 or more from IDPA in 1968. Such evaluation not to be an indictment, but an evalua-

*(Abstracts continued on page 99)*



# Behavior Modification

The use of punishment to modify behavior sometimes is self-defeating, studies in progress at The University of Chicago seem to indicate. When punishment either is too severe or not clearly related to its cause, the corrective value is lost altogether.

This observation was made by James B. Appel, Associate Professor of Psychiatry in The Pritzker School of Medicine of The University of Chicago.

The effects of punishment on behavior is one of two main areas being investigated by the 34-year-old psychologist. The other is interaction between drugs and behavior. Appel believes his experiments with pigeons, cats, monkeys, and rats have obvious implications for behavior modification in other species, including humans.

Once techniques of punishing and reinforcing behavior have been analyzed and refined in the laboratory, he commented, it may be possible to use them effectively in various behavior modification situations, including teaching.

According to Appel, if punishment is to be used effectively, its purpose must be to suppress a specific pattern of behavior while providing the same or greater reward for the desired behavior pattern. "If punishment is too mild," he noted, "the inhibiting punishing stimulus is not effective. If it is too severe, a nonspecific anxiety or fear state may occur so that all behavior leading to reward is inhibited."

Lysergic acid diethylamide (LSD) has been the drug most often studied in terms of effect on behavior, although various stimulants and sedatives also are being

investigated.

According to Appel, "LSD is extremely potent in low doses in animals, as well as in man, and probably acts directly on certain endogenous neuronal and neurochemical systems." The effects are similar to those seen in some acute psychoses.

Low LSD doses apparently affect food-motivated behavior more than avoidance behavior. That is, if a rat has been pressing a lever to obtain food, he may simply stop after a low dose of LSD. However, he will continue to try to escape from an unpleasant situation.

Escape behavior is markedly resistant to any type of drug but is affected most by central nervous system depressants. Additionally, LSD may enhance the noxious value of unpleasant stimuli.

With small doses of LSD, the physical appearance of rats does not appear abnormal. Behaviorally, however, the animals are more easily distracted and have difficulty in sustaining performance.

The relative potency of the variety of so-called psychedelic or psychotomimetic drugs, such as LSD, in the rat apparently is the same as in humans, Appel said. This also is true for the patterns of tolerance and cross-tolerance.

Tolerance means that as the organism becomes accustomed to a drug, increasingly larger doses are needed to produce an effect. Men or animals tolerant to LSD also are tolerant (cross-tolerance) to mescaline or psilocybin. Accordingly, basic behavioral and biochemical data can be gained from such study in the rat.

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## ON THE COVER

This month we commemorate 70 years of journalization of the Illinois State Medical Society's affairs and activities as well as scientific papers.

Since its inception the *Illinois Medical Journal* has come a long way. It is designed to meet the needs of the Illinois practitioner of medicine so far as such may be met by a state journal. It is specializing in all specialties and providing information on wide-ranging topics in medical and social-economic fields. It is a means for the Illinois physician to express himself.

Constantly striving for improvement, a recent report from a professor at the University of Missouri School of Journalism has helped to bring further change. Extracting from the report: "This is a far better graphic product than the average state medical journal. . . . The IMJ is trying for appearance. It shows it is not wedded to professional stagnation. . . . Photos are in excellent size. . . . Covers, individually, are high in quality."

Thus, at this anniversary year, 70 years since the first monthly format IMJ, we pay homage and tribute to all those in Illinois medicine who have helped to make the IMJ what it is today.

WHAT'S  
SO WEAK  
ABOUT  
THE WEAKER  
SEX?

## Founder of a State Medical Journal

Dr. George N. Kreider

BY KENNETH H. SCHNEPP, M.D./SPRINGFIELD

The obituary of Dr. George N. Kreider appeared in the February, 1922, issue of this *Journal*.<sup>1</sup> Among a not inconsiderable number of accolades appeared the statement: "One of the founders of the *Illinois Medical Journal*."

The available information, indeed, indicates that he was *the* founder!

### Background

But before combing the details that may be found, it is best to lay a background, rather brief, of the conditions of practice in the last third of the century, between the Civil War and 1900. The physician of today finds it very difficult in the modern

atmosphere of educational requirements, topped by the ritual of residencies and licensure, to understand the primitive rudiments of that period. This was a time in which almost anyone could call himself doctor, and did!

And why not? A short time spent in an apprenticeship with a "course of lectures" or two set one up in business. "Medical Schools" blossomed and faded. As late as 1910 the Flexner<sup>2</sup> report listed 14 medical schools in Chicago in contrast to five today. (One physical plant was the Illinois Medical College in the daytime, the Reliance Medical College at night). There were all varieties of practitioners: practicing botanists, root doctors, eclectics, Indian doctors, homeopaths, osteopaths, regulars and others.

In truth, the results of therapy, no matter what the philosophy, probably varied very little. There was a serious uncertainty over basic theories, not only within the field of science itself, but as understood by the public as well. All that was required



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founder of the *Bulletin of the Sangamon County Medical Society* and the Springfield Medical Library Association. In addition, he has served as a member and chairman of the Medical Examining Committee, State of Illinois, and as a member of the Examining Institute, Federation of State Medical Boards of the United States.





**Fig. 1. Dr. George Noble Kreider, 1894. Herbert Georg Studio, Springfield, Illinois.**

was a Thompson, a Hahnemann, or a Still to boldly and vigorously boast of cures; they proved it by wearing a long coat and affecting a full beard. There were no double blind studies or similar statistical measures of efficacy. Very few, indeed, were the societies with their publications, to act as a forum for the interchange of ideas.

The decade, 1870 to 1880, has often been termed a golden era in modern scientific medicine. Obviously, this is a somewhat arbitrary classification. But it is significant that, generally speaking, this period was marked by such names as Lister, Koch, Pasteur, Aschoff, Darwin, Virchow, Billroth, Ehrlich, and a host of others, whose work spearheaded a scientific revival that formed the very basis of modern science.

This period also saw the beginning of many special societies. The three anthropological societies (London, Munich, Florence) were founded in 1871. The next year the American Public Health Association and the German Surgical Association were organized. Other significant foundings were the Boston Medical Library (1875), Physiological Society of London (1876), American Chemical Society (1876), *Journal of Physiology* (1878), *Index Catalogue of the Surgeon General* (1880), and the American Surgical Association (1880).

### Kreider Begins Practice

It was in such a scientific and philosophical atmosphere that Dr. George Kreider began practice in 1881. He was set apart, from the start, by possession of a baccalaureate degree, a rarity in those times. Four years later, he went to Berlin to attend Koch's first course in bacteriology. He remained nine months, spending most of this time in Vienna (the fountain-head), but also observing leading surgeons in Berlin, Paris and London. He later took short courses, chiefly in surgery, at Jena (1890), Berlin (1894), Göttingen (1897), Strassburg (1903), and Heidelberg (1908).<sup>3</sup>

A significant fact remains: This young physician, shortly after starting practice, was exposed to the philosophies of science that subsequently yielded epochal progress in healing and prevention of disease. Remarkably few of his colleagues had this exposure. Many were violently antagonistic to these foreign ideas.

Probably as a defensive reaction, the local medical society became a screening device to separate the sheep from the goats. As an example, Dr. Kreider was listed, in 1889, as a delegate to the Illinois State Medical Society from the District Medical Society of Central Illinois.<sup>4</sup> This approach made him a member of the State Society with full voting rights. Other members could be certified by the local societies but they had no voting rights. The result was a tightly policed society of under 600 in a potential of 8,000 practitioners.

There is much in Dr. Kreider's career to suggest that he inspired changes in the structure of the Illinois State Medical Society and the *Illinois Medical Journal*, and that he continued to encourage the formation of county medical societies.

### Curriculum Vitae

George Noble Kreider,<sup>5-6</sup> (Fig. 1) was born in Lancaster, Ohio, October 10, 1856, a son of Edmund Cicero and Mary (Gates) Kreider. His paternal grandfather, Dr. Michael Zimmerman Kreider, was a leading physician of Ohio in the first half of the nineteenth century, practicing in Lancaster from 1825 until his death in 1855. He was a secretary of the first medical convention held in Ohio in 1835. He was active as a Mason and was the first to hold office as grand commander of the Knights Templar of Ohio in 1843.

In 1870, when George N. was 14, his family moved to Jacksonville, Illinois, where he continued his education. His father, Edmund Cicero, was serving as postmaster of Jacksonville at the time of his death, September 8, 1905.

George N. attended Washington High School in Jacksonville from which he entered Ohio Wesleyan University at Delaware, Ohio. He graduated in 1877 with the degree of Bachelor of Arts. His next step was a course of lectures at the Miami Medical College of Cincinnati, Ohio, the customary method, at that time, of entering the field of medicine. There followed two more courses in the medical department of the University of the City of New York from which he was given his doctorate in February, 1880. The following May he began the practice of medicine in Springfield, Illinois. Of some interest is his association with the Jacksonville dentist, Dr. Green Vardimon Black, with whom he studied histology during the summer after his first course of lectures.

The first significant incident in the young physician's practice was triggered by the great smallpox epidemic of 1882-83, at which time he was appointed a special inspector for the Illinois State Board of Health. He served as a member of the Board of Health from 1884 until 1887. Incomplete records indicate that he served as a member of the Board of Health of the City of Springfield for about 10 years (1887-1896).

On the 18th of February, 1894, Dr. Kreider was married to Emma Pasfield, daughter of Dr. George and Hathaway (Pickrell) Pasfield of Springfield. Five children were born: George Pasfield, April 10, 1895; Mary Hathaway, April 28, 1896; Paul Gates, February 21, 1898; Emma Jane, January 27, 1900; and Salome Carpenter, June 11, 1907.

Emma Pasfield's grandfather, George Pasfield,<sup>10</sup> was born in October, 1792, in London, England, and, as a child, came to Philadelphia with his parents, who later died of yellow fever. Thereafter, George pursued an interesting career, mostly in shipping produce and later in real estate. He subsequently settled in Paris, Bourbon County, Kentucky, where he continued as a grocer and in packing pork and shipping. He was married in Paris, January 5, 1821, to Mary Forden. The couple moved to

Springfield in the spring of 1821 where one child, George, the father of Emma, was born November 30, 1831. He studied medicine and graduated from St. Louis Medical College in the class of 1855-56. Dr. George Pasfield was married September 19, 1866 at Mechanicsburg, to Hathaway Pickrell. They had two children, Emma and George. After his father's death, Dr. Pasfield found himself with so many business responsibilities that he retired from the practice of medicine and became an enterprising and successful merchant. He was one of the signers of the 50 thousand dollar note to secure the location of the capitol at Springfield.

### ISMS Membership

The name of G. N. Kreider first appeared as a member of the Illinois State Medical Society in 1889 as a delegate and he was further listed as a member of the Standing Committee on Surgery. During the meeting of 1891, he was elected treasurer of the State Society,<sup>7</sup> and, probably of more significance, was named to the Committee on Publications. The latter committee controlled the publication of the *Transactions* and the papers appearing in it. He remained treasurer of the Society until his election to the presidency in 1901, and remained exceedingly active in publication matters during this period. In 1893 he was elected a delegate to the American Medical Association. During the period from 1889 until well after the turn of the century, Dr. Kreider never missed an annual meeting of the Illinois State Medical Society. He presented papers on a variety of subjects during these years and actively discussed the papers of other speakers.

Small wonder, then, that Dr. Kreider's advice, offered during the 49th annual meeting in Cairo, May 16-18, 1899, was followed. He proposed that the *Transactions* published for almost 50 years annually, be superseded by a monthly journal.<sup>8</sup> His greatest argument was a letter from Dr. Adolph Koenig of Pittsburgh, Pennsylvania. This was dated March 16, 1899, and was read by Dr. Kreider at the Cairo meeting. It appeared that the Medical Society of the State of Pennsylvania had converted from an annual transaction volume to a monthly journal about two years previously, and Dr. Koenig, its editor, became somewhat lyrical in his praise of the new jour-



**Fig. 2.** The first editorial office of the Illinois Medical Journal, 522 East Capitol Avenue, Springfield, Illinois. The exact date of the photograph is not certain, but it was published by the Illinois State Journal in 1892 and is reproduced from microfilm of the Illinois State Historical Library. Dr. Kreider is standing by his office. This building was later removed to 1014 South Fifth Street and remodeled into apartments.



nal and its benefits.

Dr. Kreider's comments take up a number of pages, but there follow some quoted highlights.

*"To increase the membership and extend the influence of this Society until it shall reach every practitioner of medicine and through him every individual in the commonwealth is doubtless the sincere wish of every person now holding allegiance to the organization. . . . The advantages of the journal are first and foremost. It keeps the State Society alive and before the profession throughout the year. . . . By reason of its periodical appearance members are kept in mind better of their duties to the society. . . . What will the establishment of a journal accomplish? First, the change is likely to add a large number to our membership. . . . The number is now barely 600 in a state having about 8,000 regular practitioners."*

### IMJ Appears

As a result, the first issue of the *Illinois Medical Journal* appeared in July, 1899,

published from an office at 522 E. Capitol Ave., Springfield, with Dr. Kreider as editor. (Fig. 2 and 3) He was to remain its editor until 1913, and apparently continued to hold this post in 1901, while serving as president of the Illinois State Medical Society.

Although the title on the spine of my volume is "*Illinois State Medical Society Transactions—1899*," the title page is reproduced. (Fig. 4)

This same year, on November 14, the Springfield Medical Club held a regular meeting in the County Court Room with George N. Kreider as chairman. Emboldened by the success of the *Journal* founding and probably acquiring further influence by virtue of it, he proposed to organize a county medical society. A committee was appointed to formulate a constitution and by-laws, and, at the next meeting on December 11, 1899, in the County Court Room, Odd Fellows Building, the original constitution of the Sangamon County Medical Society was adopted and Dr. Kreider was elected its first president.

His contribution to surgical technique at St. John's Hospital, where he was appointed visiting surgeon in 1891, bears review. Lister's work on antiseptics in surgery had been published approximately 10 years before, despite Holme's and Semmelweis' previous work on puerperal fever. In those days, knowledge did not travel rapidly, and young Dr. Kreider, with his exposure to European antiseptic methods was well ahead of his colleagues in Springfield. His experience, as set down in one of his publications,<sup>11</sup> is of great interest. After mentioning his choice of hand brush ("Ladies hand brush, second quality, . . . because the bristles are not too stiff and when soaked do not lacerate the skin"), he gives detailed instruction for scrubbing, trimming nails, avoiding lacerations and skin irritations, treatment with alcohol and bichloride solution. He then states: "It will be observed that bichloride or carbolic acid plays a very small part in the preparation of the hands, and it cannot be too often repeated that merely soaking the hands in a solution of these germicides is of no



value at all. The grease and dirt of the hands must be removed by an alkaline soap and the expenditure of good, strong scrubbing. If anything is to be left undone it should be the use of the antiseptics."

Later, Dr. Kreider was visiting surgeon at Springfield Hospital. He was consulting surgeon, and subsequently in charge of the Wabash Railroad Hospital from 1891 until 1903, when it was moved to Decatur. He was also active in local societies other than Sangamon County, serving as president of the Capital District Medical Society (1894), president of the District Medical Society of Central Illinois (1895-1896), and was a member of the small select Central Illinois Clinical Surgeons Association. He was made a Fellow of the American College of Surgeons in 1913.

Dr. Kreider found time to be active in the Illinois National Guard and was initially commissioned Major and Second Brigade Surgeon on May 26, 1896. A year later he became Assistant Surgeon General with the rank of Lieutenant Colonel.<sup>12</sup> In 1898, he became the Post Surgeon at Camp Tanner (the Illinois State Fair Grounds) where the Guard assembled for Spanish-American War Duty, April 27 to June 4). He resigned July 19, 1900, but re-enlisted in the Guard on December 15, 1901, as a major attached to the 5th Infantry and served until March 28, 1904. During World War I he was president of the Medical Examining Board of the Central Illinois District processing applicants for Reserve Commissions.

He was the author of 28 medical articles published between January 1885, and April 1920. He died January 4, 1922, of pernicious anemia and is buried in Oakridge Cemetery, Springfield.

The conclusion is reached that Dr. Kreider was, in fact, the founder of the *Illinois Medical Journal* and served for many years as its editor. He worked incessantly to further the best interests of state and local societies. And finally, he introduced, in Central Illinois, the basic precepts of antiseptic surgery, fundamentals that have endured to this day. ◀



**Fig. 3.** Dr. George N. Kreider at his office desk, 522 East Capitol Avenue, Springfield, Illinois. This was taken in October, 1899. *Herbert Georg Studio, Springfield, Illinois.*

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## Ed. Note:

We are greatly indebted to Dr. Schnepf for his excellent account of early *IMJ* history and the events surrounding it. His research has enabled a clearer understanding of the founding of this journal and the role and scope of a state medical journal publication. In this commemorative anniversary issue we pay homage to those who have contributed so much to make the *IMJ* what it is today.

# ILLINOIS MEDICAL JOURNAL

CONTAINING THE

Official Record of the Proceedings of the Illinois  
State Medical Society

MEETING AT CAIRO, MAY 16, 17, 18, 1899

AND THE

PROCEEDINGS OF AFFILIATED CITY, COUNTY AND DISTRICT SOCIETIES

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EDITED FOR THE SOCIETY BY THE  
PUBLICATION COMMITTEE:

E. W. WEIS, M. D.  
OTTAWA

H. N. MOYER, M. D.  
CHICAGO

G. N. KREIDER, M. D.  
SPRINGFIELD

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VOLUME XLIX.--NEW SERIES, VOLUME I.  
July, 1899 to June, 1900

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SPRINGFIELD:  
ILLINOIS STATE JOURNAL PRESS

*Fig. 4. Title page of Volume I, Illinois Medical Journal.*

# The Illinois Medical Journal and the State Society

By RICHARD A. OTT/CHICAGO

For many decades the formation of the Illinois State Medical Society was believed to have taken place on June 4, 1850. But in 1937, research of the late Dr. L. H. Zeuch showed that the society was actually formed in 1840. The 1850 meeting seems actually to have been a reorganization of an existing but perhaps waning society.

In 1817, even before Illinois attained statehood, a few physicians in various, detached localities, had organized into professional societies. The results of these activities were evidenced by two acts incorporated by the General Assembly. The first, in 1819, was an "Act for the Establishment of Medical Societies," and the second, in 1825, an "Act Prescribing the Mode of Licensing of Physicians." Both acts were repealed soon after adoption.

The first district society established under the former act, in 1819, was organized by Dr. John Todd. At the meeting in 1840, Dr. Todd was instrumental in setting up the first state medical society. This Dr. Todd is also part of the family into which Abraham Lincoln married.

Records show that many county societies and some city societies were organized in these early years. Some of these were merged into the reorganized state medical society in 1850. A few have been maintained to the present but the majority functioned for a few years and then disbanded. Among those remaining is the Aesculapian Society of the Wabash Valley and it, along with the Ottawa Medico and Chirurgical Society, was mainly responsible for the rejuvenation at Springfield, in 1850.

Thus, the state society is reckoned to have begun officially in 1840. The state had been admitted to the Union only 22 years prior, and in 1840 numbered 476,183 in-

habitants, of whom a mere 4,470 lived in Chicago. The population consisted of Indians, half-breeds, hunters and trappers, slave catchers, and the adventurous Easterners who were arriving in increasingly greater numbers. They came from all walks of life as free land beckoned and expanded opportunities opened.

The wide prairies of the new state were low and swampy. Though dry in summer, they often were flooded for many other months. There was plentiful wildlife and native flora on which the early hunters and settlers earned an existence and the virgin farmland produced bounteous harvests of crops for the neophyte farmer.

Physicians, however, will appreciate that in the swamp conditions extant, malaria abounded. All types of physical disability evident during that epoch were rampant, and were at times aggravated by the environment. Epidemic proportion diseases often swept the state leaving a devastating wake of death.

Chicago was a crude frontier town, a formless collection of shacks and shanties. Of sanitation measures it had none; down-state areas fared no better. The death rate in Chicago exceeded 75 per 1,000. In 1850 the population of Chicago had increased to 29,693 and Illinois numbered 851,470.

Dating back briefly again to 1840, the inception date of the State Society, one finds that this was three years before the establishment of the long revered Rush Medical College, the first educational institution of this nature in Illinois, and three years before Dr. Oliver Wendell Holmes promulgated the infectiousness of puerperal fever. It was two years before Long's discovery of ether and two years before the first surgery under ether anesthesia. It was also seven years before the first use of chloroform and before the formation of the American Medical Association.

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**Mr. Ott is Director of Publications for the ISMS and IMJ Managing Editor.**



tion, which was then referred to as the National Medical Association. In 1850 the Chicago Medical Society was founded.

In 1840 there were only 5,000 miles of railroad tracks in the United States, which consisted of just 26 states, with an area of 940,000 square miles (today it is 50 states, with 3,615,210 sq. mi., excluding the Great Lakes). Martin Van Buren was president and the presidential candidates of the year flying the slogan "Tippecanoe and Tyler Too" were victorious. Thomas Carlin was governor of Illinois and the Mormons had just arrived to establish a colony after being driven from the east. Abraham Lincoln had begun his law practice and had vowed that if he ever had the opportunity to fight slavery he *would hit hard*. The Dred Scott decision lay two decades in the future.

Queen Victoria had been on the throne of England a scant three years, and in 1840 married Albert. Louis Philippe was king of France; Germany was a group of indistinct, incohesive principalities. The Irish famine was still to come; Italy was a grouping of 14 states and provinces; Turkey ruled Romania. Japan had not yet been "opened" by Perry; European ships sailed to India around the Cape of Good Hope; Australia was known only as a convicts' colony.

After the Society's establishment several events of world importance are marked. Gold was discovered in California in 1849, Napoleon became Emperor of France in 1852, the Crimean War began in 1853, Perry sailed into Japan in 1854.

Thus, these early years so dear in the study of history, were contemporary with the founding of the Illinois State Medical Society.

But the *Illinois Medical Journal's* history is not that of the state society.

The organization meeting of 1850 adopted a brief constitution, setting meeting dates, dues and committees. A code of ethics was also adopted. The *Northwestern Medical and Surgical Journal*, already in existence, was authorized to prepare and publish abstracts of actions of the society. These "Transactions" provide the continuing history of the early society and are the forerunner of the present *Journal*. These were published annually until Vol. 48, of 1898. (The Vol. 48 numeration was due to the fact that the founding date was er-

roneously reckoned back only to 1850.) By that time 630 pages were needed to cover the activities of the society at the annual meeting and to publish the papers presented. Membership was 600, representing 37 counties, 20 cities, and 15 Districts—as formally constituted societies. While the paid membership was low, the total number of practitioners was in the vicinity of 8,000: at one time in the half century there were more practitioners of medicine in Illinois than in any other state of the union.

As the years went by, the amount of space necessary to publish the "transactions" in the *Northwestern Medical and Surgical Journal* had become increasingly greater. It was probably only with great effort that the practitioner was able to read and digest the entire volume.

The necessity of abstracting and shortening the proceedings and publishing papers separate began to be apparent. As early as 1885 reference is made in the proceedings of the House of Delegates that an Editor should be appointed, who would also be the chairman of the publications committee. Sentiment favoring journalization began to be expressed in 1886 and a resolution to this effect was introduced. It failed. At the Cairo meeting, 1899, the house was memorialized to begin a journal, as the American Medical Association had done in 1893 and as Pennsylvania did in 1897. One of the chief arguments proffered was the fact that all practitioners could be reached more readily and oftener. Thus, the membership would be increased, numerically and educationally. Of the 8,000 physicians in Illinois, only 540 were members, of whom 260 were delegates to the House. A committee which had been studying this matter recommended that journalization be begun in July, 1899, and such action was authorized. The first issue came out on schedule. Thus, Illinois was the second state to publish its own journal. And it was a wholly owned publication, being the first journal in this category. In 1900 the circulation was 1,250 and in 1901 advertising began to be accepted. By 1904 the circulation had increased to 4,500 and the average issue contained 132 pages.

The publicity through the *Journal* had an immediate effect. A 1901 report stated "the *Journal* has in large measure been instrumental in awakening the increased in-

terest that is seen throughout the state in the Illinois State Medical Society." Society membership increased some 40% each of the first two years of publication.

Initially the *Journal* incurred a deficit. But by 1905 it was possible to lower the subscription price from \$3 to \$2, wipe out past deficits, and allow for the next thirteen issues. The *IMJ* was truly established. In 1908, at a Peoria meeting, it was suggested that the *Journal* become a weekly publication. This did not come to pass.

Since its inception in its present issue format, e.g. a monthly, the *Illinois Medical Journal* has had five editors. Each of these men conducted the work of the *Journal* as a labor of love. Through the pages various concerns of professional medicine have been discussed and editorialized. In many instances, a strong stand has been taken which in the course of events proved a correct stand and pointed to the *Journal* as a truly representative spokesman for Illinois medicine.

The first editor was Dr. G. N. Kreider, of Springfield. He was a leader in the movement to journalize the transactions and served on the early publications committee.

His tenure ended in 1913 when Dr. Clyde Pence took over the helm with Dr. Henry G. Ohls as managing editor. In 1919, Dr. Pence relinquished the task to Dr. Charles J. Whalen, Dr. Ohls remaining as managing editor. Upon the demise of Dr. Whalen in 1941, Dr. Harold M. Camp, who also served with distinction as secretary-treasurer of the state society, took up the reins as editor. The present editor, Dr. Theodore Van Dellen became associate editor April 1, 1949, during the tenure of Dr. Camp. When Dr. Camp died in 1959, Dr. Van Dellen became the editor.

The *Illinois Medical Journal* has been a pioneer in many aspects of medicine. It has been an outstanding spokesman. The same spirit which in 1840 led a small group of men gathered in Springfield to embark upon a new state-wide concept of medical organization maintains in the present *Journal*. The *Journal*, while not aspiring to national or international repute, is pledged to foster and maintain the profession as an individual entity and to serve the needs of the Illinois medical practitioner. ◀

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### THE IVORY TOWER

With the realization that American medicine is at a crossroads, we all need to examine our present methods for delivering medical care especially as it applies to the community. As important and essential as the large medical centers remain, the fact of American medical life is that most medical care is delivered in the communities away from the centers and often in the hospitals of 100 beds or less. Most efforts until recently have concentrated on problems as seen from the ivory tower. More attention must be paid to the areas where the bulk of America is and from the point of view of doctors in the field. Patient care need not be directed entirely from the medical center. In fact, the continuing sapping of medicine's strength by the large centers will ultimately destroy the very gains the centers themselves espouse. No one doubts the greatness of our medical centers, but all can agree that the great advances that they achieve are often a long time in coming to those a distance away. If there is one central failure of academic medicine in this country it is this failure to translate its enormous progress effectively and promptly to the local level. If there is one central danger of academic medicine it is the seduction of its younger men, who remain at the ivory tower unwilling to reach out into the jungle that they envision the outside world to be. And, finally, if there is one failure of community medicine, it is its diminishing attractiveness for the younger men in academia. Some of these problems I will attempt to delineate with the deep faith that nothing is insoluble with an open mind. (Russell S. Hoxie. "A Time for Study and The Need for Change." *New England J. Med.* 280:20 [May 15] 1969, pg. 1099-1101.)



### NEIGHBORHOOD HEALTH CENTERS

Neighborhood health centers may be the answer to better care for the poor. To supplement the report on "Community Child Care: The Role of the Neighborhood Health Center," page 67 of this journal, we will mention the study conducted at Columbia Point Neighborhood Health Center in South Boston. According to Bellin et al.,<sup>1</sup> during the first two years of operation, there was an 84 per cent reduction in admissions of people from this area to Boston City Hospital. In addition, there was a drop in the total bed days spent in the hospital.

In the opinion of these investigators, the community previously had a large pool of unrecognized and unattended health prob-

lems. The decline in hospital admissions was accomplished primarily by the effective treatment of early illness and minor injury rather than by prevention. There was evidence that ambulatory health care services prevent and effectively treat illness that otherwise might require hospital care. In addition, the centers reduce the number of days in the hospital by supervising the post-hospital convalescent care of patients who no longer require intensive hospital care.

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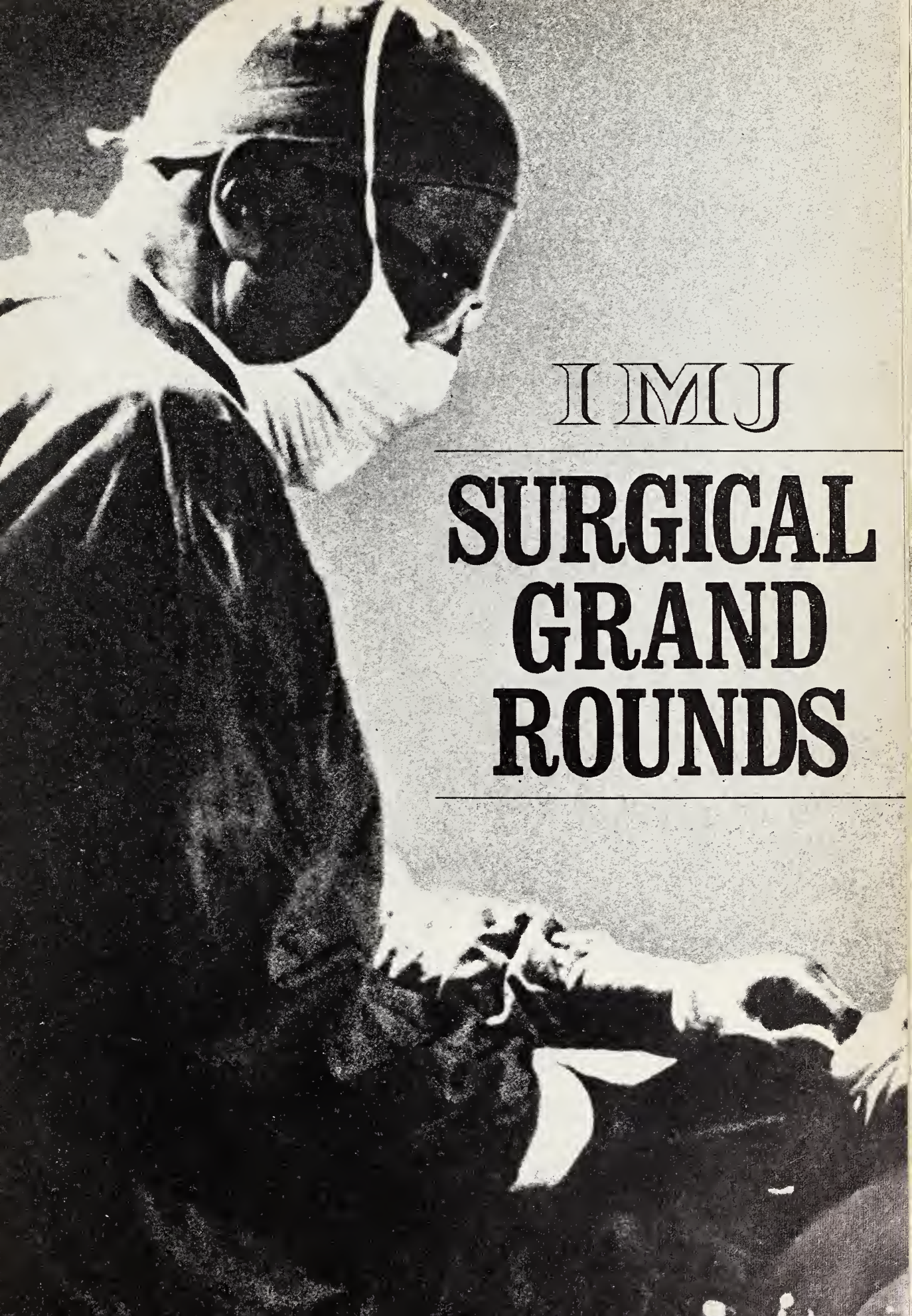
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"Everything made by human hands looks terrible under magnification—crude, rough, and unsymmetrical. But in nature every bit of life is lovely. And the more magnification we use, the more details are brought out, perfectly formed, like endless sets of boxes within boxes."

Roman Vishniac

In Andreas Feininger, *FORMS OF NATURE AND LIFE*  
The Viking Press, Inc., New York, 1966.





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# **SURGICAL GRAND ROUNDS**

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Fig. 1—Bilateral supracondylar fractures are shown, with posterior displacement of the distal fragments.

# *Fracture of the Femur with Popliteal Arterial Injury*

EDITED BY JOHN M. BEAL, M.D.

*Surgical Grand Rounds are held weekly on Saturday at 8:00 a.m., alternating between the Staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds held at Passavant Memorial Hospital on March 8, 1969.*

## Case Report

**Dr. Bates Noble:** The patient is an 18-year-old college student who works part time in a local publishing firm. On February 24, he was pinned between a truck and a loading platform. He was given morphine at the site of injury and was transferred to the emergency room at Passavant. At that time, both thighs were markedly swollen and quite obviously deformed. Neither dorsalis pedis nor posterior tibial pulses were felt on the right lower extremity. The right foot was much cooler than the left. The left lower extremity had good pulses. The capillary return under the nails of the left foot was good. He complained of some numbness in the foot. He was treated with intravenous fluids and was crossmatched in the emergency room. X-rays were obtained.

**Dr. Michael Murphy:** Films show supracondylar fractures of both femurs with posterior displacement of both distal fragments (Fig. 1). A right femoral arteriogram done immediately after these films were taken demonstrates occlusion of the popliteal artery just distal to the fracture site (Fig. 2). Although the occluded segment measures four cm. in length, the artery is intact because no extravasation is seen. The popliteal fills through collaterals and the lateral superior, and inferior genicular arteries are seen here. We thought that the most probable cause of the occlusion was intramural hematoma. Post-reduction films showed satisfactory alignment of the fractures (Fig. 3).

**Dr. David Bachman:** There are two major complications from supracondylar fractures. The one that is by far the most urgent and must be resolved immediately is the one we are going to discuss this morning. That is occlusion of the popliteal vessels. The X-rays illustrate the cause for this problem. In a supracondylar fracture, the short distal fragment has only one muscle attachment, the gastrocnemius. The two heads of the gastrocnemius attach to the femoral condyles and the unopposed pull of this muscle tips the distal fragment posteriorly. If one recalls the anatomy of the popliteal fossa, the vessels pass through the floor of the popliteal space, close to the femoral shaft and then pass between the gastrocnemius heads to get into the lower leg. With the distal fragment tilted



**Fig. 2—Right femoral arteriogram demonstrates occlusion of the popliteal artery.**

posteriorly, the vessels are tightly stretched across this fragment and subject to injury. Dr. Conn is going to speak at some length about popliteal vessel injuries and I'll stop at that point.

The second complication is generally caused by the proximal fragment. The proximal fragment penetrates the quadriceps muscle as well as the suprapatellar pouch. The suprapatellar pouch extends three to four inches above the patella and as you can see, the proximal fragment is impinging into this area. This man is going to have scarring and fibrosis of the quadriceps muscle from tearing the suprapatellar pouch. The prognosis for a full range of motion in this man's knee is quite small. The major limitation will be loss of full flexion, but there will probably be some extension loss as well.





**Fig. 3—***Post-reduction films show satisfactory alignment of fractures.*

Fractures in this area heal relatively well. The usual time is about 12 weeks. This man had an open reduction for this fracture primarily to stabilize the leg so that the vascular repair would be maintained. Also, we can mobilize him faster this way. We hope to start motion in six weeks. Since these films were taken we have also done an open reduction on the other side. It is quite important to get as accurate a reduction as possible. With overriding of these fragments, the chance of motion being restored completely is lessened because of increased fibrosis both around the quadriceps muscle and the suprapatellar pouch. The total recovery time will be at least one year for maximum attainable function.

**Dr. John Beal:** Dr. Bachman, did the bone penetrate the skin on one side?

**Dr. Bachman:** There was a wound on the posterior aspect of the right thigh, at about the level of the knee joint. This wound was probably secondary to the force of his being impinged against the loading dock and not from bone penetration. The hole was a little too distal to the area of the fracture. For the proximal fragment to penetrate posteriorly and end up with anterior displacement would be unusual.

**Dr. Beal:** Why did you choose the type of fixation you used rather than an internal fixation with a bar?

**Dr. Bachman:** Well, I think you have two choices here. One is this blade plate or the other would be two Rush rods. This is too low for a Kunschner or a Schneider rod. An intramedullary rod holds by its contact with the medullary canal all around. To get a rod of sufficient size to hold this fragment it would be impossible

to slide it up the canal. Any fracture below the junction of the middle and distal thirds of the femur, where the medullary canal starts to widen, is not suitable for fixation with that type of an intermedullary rod. We could have used two Rush rods and inserted them from each condyle but I think you would get more stability with this kind of fixation than you do with Rush rods.

**Dr. Julius Conn, Jr.:** Merely repairing the bone would probably have left this boy severely disabled. During World War II, following ligation of major arteries the amputation rate was 49%. Following arterial repair the amputation rate fell to 36%. The major reason for the poor results following arterial repair was the long delay from the time of injury to the time of repair. In young patients the collateral flow is poor so the ischemia is quite severe and irreversible muscle necrosis will develop in six to eight hours. During the Korean War the amputation rate following major vascular injuries was 21% in 1952. By 1953, with better transportation of the injured and earlier surgery the amputation rate dropped to 14%. Table I shows the relative frequency of vascular injury as seen in wartime and civilian injuries. The major difference is found with upper extremity injuries. This is related to dislocations and fractures about the shoulder and elbow and also to lacerations of the upper extremities seen in the civilian population. It is important to look for associated nerve injuries since about 40% of the lower extremity vascular lesions will also have nerve damage. In the upper extremity, nerve injuries are even more frequent. If the superficial femoral artery or popliteal artery is ligated rather than repaired, three-fourths of the patients will lose their leg. If there is an open fracture or dislocation of the knee and the popliteal artery is ligated, 98% of the patients will come to amputation. Patients who have not had primary repair and have not required amputation may have debilitating ischemia with claudication. Any patient who has an injury in or about the major vessel, especially if there is diminution or absence of the distal pulses, should have an arteriogram.

**Table I**

Civilian		Wartime
20%	Femoral	30%
20%	Popliteal	25%
40%	Brachial	20%
20%	Other	25%

Following blunt trauma the idea that spasm occurs had led to loss of many limbs. Periods of waiting and delay waiting for "spasm" to disappear leads to muscle necrosis. Although one may then restore pulses to the limb, Volkmann's ischemic contracture or gangrene develops. This case illustrates how this might happen. From the time this boy was first seen he had a relatively cold, pulseless limb with hypesthesia and numbness. By the time he was moved to the X-ray department the hypesthesia had disappeared and he had regained full control of the muscles of the right foot. The foot was warmer, and capillary refill had returned. Capillary refill was 15 to 20 seconds over the injured foot and 2 seconds on the opposite side. Had we given vasodilators and waited for the "spasm" to diminish this boy probably would have developed severe irreversible ischemia. At the time of surgery there was contusion and stretching of the popliteal artery with the intima completely disrupted. The intima completely divided over a distance of two centimeters. After dividing the distal popliteal artery there was absolutely no back flow from the vessel. After passing a Fogarty catheter and extracting several clots back bleeding was obtained. The distal circulation was heparinized in order to prevent further clotting while Dr. Bachman stabilized the bone fragments. A segment of saphenous vein, immediately adjacent to the incision, was removed and used as a graft to restore the distal circulation. He had full return of pulses immediately after the clamps were removed.

Late problems following blunt or penetrating injuries to the leg are the occurrence of arteriovenous fistulas or false aneurysms. Any patient who develops a bruit or thrill following a fracture should be investigated for an arteriovenous fistula. Patients who develop late neurologic deficits should also be suspected of having an A-V aneurysm with nerve compression. We have seen a number of patients who have had minor penetrating injuries about the knee and lower leg in Viet Nam who are now showing up at various V.A. hospitals complain-



ing of pain or weakness in the leg. Several have had A-V fistulas. False aneurysms usually occur following partial transection of an artery and vein. In summary, the initial approach to these patients is to save the patient's life. Once the patient has been resuscitated then attempts should be made to save the limb. During this time, prevention of additional trauma is extremely important. With fractures of this type it is important to restore the anatomy as quickly as possible because the vessel may be initially compressed but with further movement of the bone the artery may be lacerated or thrombosed. Finally, having saved the limb, nerve and tendon repairs are undertaken. Proper management of the soft tissue injury is critical. If the soft tissue injury is not adequately controlled, then vascular repairs will fail. Any attempt to repair

this boy's artery without first stabilizing the bone would also have failed because movement of the bone fragments would have disrupted the graft. A major factor now will be rehabilitation of this young college student. The combined approach here was carried out very quickly with minimal delay, and I hope the long term result will be good.

**Dr. Beal:** You have emphasized certain aspects that were pointed out at a recent meeting of the Central Surgical Association in February, 1969. A paper on this subject was given from the Henry Ford Hospital. The principal problem that they had was not getting the patient soon enough and not having the vascular injury recognized in association with the fracture. In addition, the necessity for immobilization of patients with long bone fractures during transplantation must be mentioned again. ◀

## *Clinics for Crippled Children Scheduled*

Twenty clinics for Illinois' physically handicapped children have been scheduled for August by the University of Illinois, Division of Services for Crippled Children. The Division will conduct fourteen general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing service. There will be five special clinics for children with cardiac conditions and rheumatic fever, and one for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

Aug. 6—Carlinville—Carlinville Area Hospital  
 Aug. 6—Alton Rheumatic Fever & Cardiac—Alton Memorial Hospital  
 Aug. 6—Hinsdale—Hinsdale Sanitarium  
 Aug. 7—Lake County Cardiac—Victory Memorial Hospital  
 Aug. 8—Chicago Heights Cardiac—St. James Hospital  
 Aug. 8—Evanston—St. Francis Hospital  
 Aug. 12—East St. Louis—Christian Welfare Hospital  
 Aug. 12—Peoria General—Children's Hospital

Aug. 13—Champaign-Urbana — McKinley Hospital  
 Aug. 14—Springfield General—St. John's Hospital  
 Aug. 19—Belleville—St. Elizabeth's Hospital  
 Aug. 20—Chicago Heights General—St. James Hospital  
 Aug. 21—Elmhurst Cardiac—Memorial Hospital of DuPage County  
 Aug. 21—Bloomington—St. Joseph's Hospital  
 Aug. 21—Rockford — Rockford Memorial Hospital  
 Aug. 22—Chicago Heights Cardiac—St. James Hospital  
 Aug. 26—East St. Louis—Christian Welfare Hospital  
 Aug. 26—Peoria General—Children's Hospital  
 Aug. 27—Springfield Cerebral Palsy—Diocesan Center  
 Aug. 27—Aurora—Copley Memorial Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.





## THE VIEW BOX

BY LEON LOVE, M.D.

*Director, Department of Diagnostic Radiology, Cook County Hospital,  
and Clinical Professor of Radiology, Chicago Medical School*

This 45-year-old male patient entered with a history of cough and pain in the chest. Physical examination revealed slight dullness at the left lung base and a temperature of 102°F.

Diagnosis:

- 1) Hiatus hernia.
- 2) Mediastinal pleural effusion.
- 3) Atelectasis of the left lower lobe.



Fig. 1

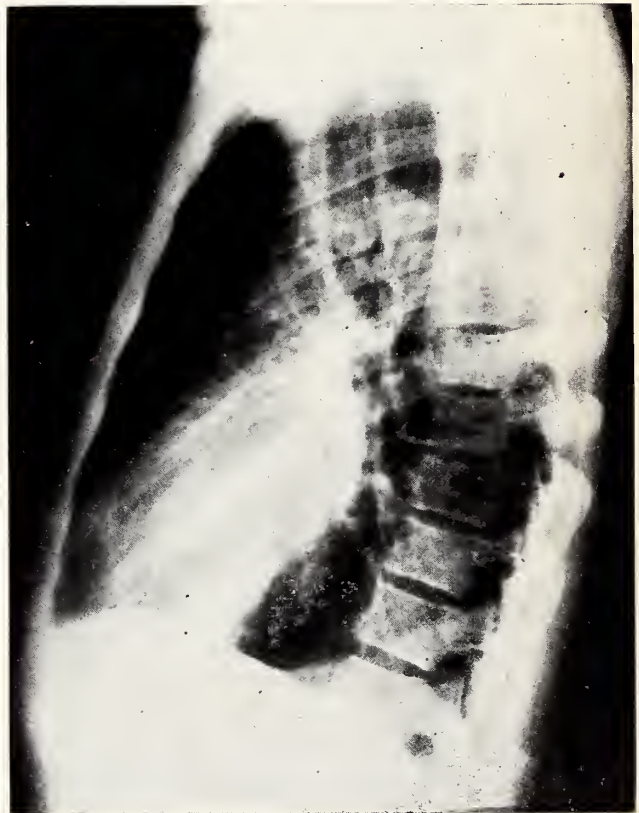


Fig. 2

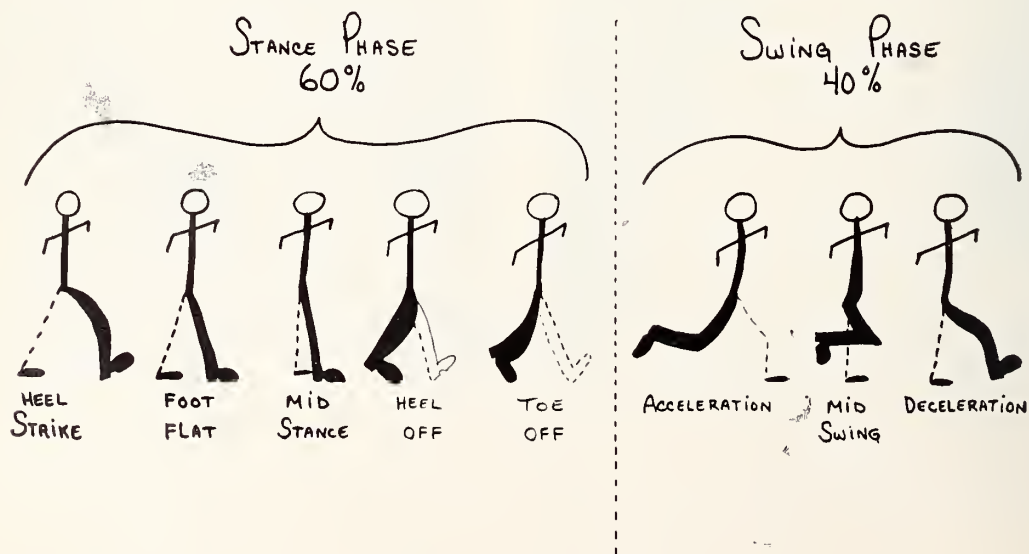
(Answer on page 110)

# Normal and Abnormal Gait Patterns

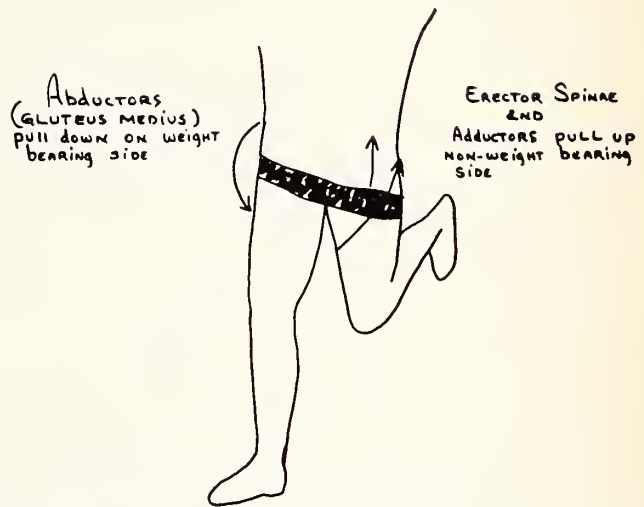
BY AARON M. ROSENTHAL, M.D./CHICAGO

*A complete physical examination should include an analysis of the patient's gait. If an abnormality exists, an accurate diagnosis is essential in order to prescribe rational treatment. However, it is necessary for the physician to understand the important components of a normal gait pattern before he can recognize the abnormal.*

FIGURE 1  
THE PHASES OF NORMAL GAIT



## TO MAINTAIN A LEVEL PELVIS



Muscles perform one of two functions in the walking cycle. In one role they act as a body stabilizer to resist the effect of gravity or inertia. In the other role they provide the motor power necessary for propulsion. A normal gait is one in which there is the most efficient use of these muscles with conservation of energy. Particularly is this true for those muscles which are body stabilizers.

### Function of Muscles

Let us examine the function of the various muscles which are important in walking. Each time the foot is raised during swing phase the pelvis loses its base of support. Without compensatory muscle actions, the pelvis will drop on the unsupported side. However, the actions of three muscle groups are normally brought into play to minimize this drop. The gluteus medius holds the pelvis down on that side. This prevents the pelvis from falling down on the unsupported swing side as shown in Fig. 2.

At the same time the erector spinal muscles on the swing side contract and the adductor muscles on that side also contract in an effort to assist in this supporting action. However, both of these muscle groups are acting on the side of the pelvis which is unsupported by a firm base and therefore, these muscles are less effective than gluteus medius which is acting on the supported side.

In this paper I will present an analysis of the mechanics involved in normal walking to be followed by a classification of the common gait deviations and a brief description of their salient characteristics. With this information a physician should be able to make an accurate diagnosis of the gait deviation he observes in his patient.

For more than 100 years researchers have been engaged in the study of gait. The Weber brothers published their findings in 1836.<sup>1</sup> However, it was not until very recently that sophisticated electronic instruments were developed to accurately analyze the various components of gait. These instruments include the electrogoniometer to record joint movements,<sup>2,5</sup> the electromyograph to record muscle action potentials,<sup>2</sup> the electroaccelerograph to measure force produced by motion,<sup>2</sup> the rapid frame motion picture camera to visualize the detailed characteristics of gait<sup>2,3</sup> and the oscillograph to record time-force relationships developed by walkers on force plates.<sup>4</sup> All of these studies have contributed to our understanding of the normal and abnormal gait patterns.

### Components Of Normal Gait

The walking cycle is characterized by two phases (Fig. 1). Each foot is alternately in contact with the walking surface during stance phase and is then lifted in space during swing phase. Approximately 60% of the cycle is spent in stance and 40% in swing. At the beginning, the middle and at the end of each full cycle both feet are in contact with the surface and there are no periods of double support.



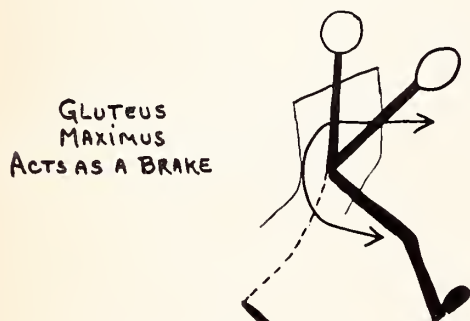
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Hospital Medical Center. Dr. Rosenthal is a member of the American Congress of Physical Medicine and Rehabilitation, as well as a Fellow of the American College of Physicians.



FIGURE 3

## TO PREVENT TRUNK FROM BUCKLING



The gluteus maximus muscle acts during the first half of the stance phase to prevent the trunk from flexing excessively. If not for this action, inertia would lead to loss of balance. The function of the gluteus maximus is illustrated in Fig. 3.

The hamstring muscles (semitendinosus, semimembranosus, biceps femoris) act to make walking graceful. Just before the heel strikes at the beginning of stance phase, the hamstrings contract to decelerate knee extension and the heel contacts the walking surface smoothly and coordinately (Fig. 4). Following this, the hamstrings then act on the hip and pull the body forward over the implanted foot.

The quadriceps muscle stabilizes the knee joint throughout stance phase. It thereby prevents the knee from buckling and resists the pull of gravity which would force the knee into flexion (Fig. 5).

The calf group of muscles (gastrocnemius, soleus, plantaris, long toe flexors) show peak activity during the last half of stance phase. It is their function to provide the propelling thrust for each step. This is accomplished by the forefoot pushing back against the walking surface as noted in Fig. 6.

The pretibial muscles (anterior tibial, long toe extensors) contract during both stance and swing phases. During stance they pull the leg across the foot which propels the body (Fig. 7). During swing they keep the ankle dorsiflexed so the foot clears the walking surface to prevent stumbling. At the beginning of stance, they maintain dorsiflexion so that the forefoot does not slap the walking surface.

### Abnormal Gait Patterns

We will now classify and describe the common abnormal gait patterns. Each pattern fits into a type as follows:

1. Inequality of leg length
2. Muscle contracture or joint ankylosis
3. Unstable supporting muscle
4. Painful weight bearing
5. Weakness of propelling muscles

FIGURE 4

## TO BRAKE THE KNEE AT HEELSTRIKE

### THE HAMSTRINGS



## FIGURE 5



### Inequality of Leg Length

The method a patient will use to compensate for a shortened extremity is dependent upon the extent of the difference between the lengths of the two legs. If the difference is not greater than one and one-half inches then the patient will drop the pelvis on the short side in order to reach the walking surface. This produces a secondary scoliosis of the lumbar spine.

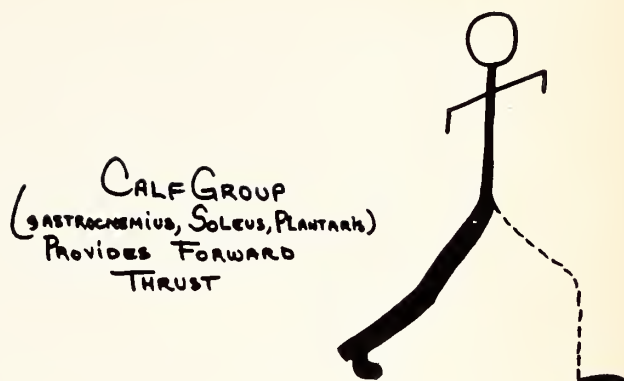
If the length difference is between one and one-half and three inches, just dropping the pelvis is insufficient to bring the shortened leg to the floor during stance phase. The patient compensates by plantar flexing the ankle on the short side and walking on his forefoot in the equinus position. This may lead to fixed gastrocnemius muscle contracture and may produce pain over the metatarsal heads.

When there is more than a three inch leg length difference walking in the equinus position is not sufficient. The patient will further reduce the leg length difference by walking with the longer leg in knee flexion. This may lead to degenerative changes in that knee joint.

### Muscle Contracture or Joint Ankylosis

A variety of bizarre gait patterns may be seen as a result of either of these conditions. Flexion contracture at the hip is a common example. As a result of the patient's inability to extend his trunk due to shortening of the iliopsoas muscle, the patient must walk with his trunk flexed. To compensate and to see where he is walking the upper part of his spine is hyper-

## FIGURE 6



extended to produce a lordosis. This posture necessitates an ungainly, jerky, short stepped gait.

If the hip joint is ankylosed, internal and external rotation of the hip are impossible. These motions enable the normal walker to rotate his trunk in a forward direction. To compensate for this loss, the patient will rotate his body at the heel and this requires the walker to maintain a stiff knee for ankle rotation to be effective.

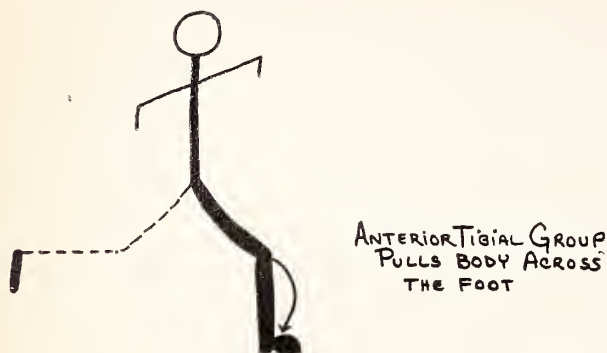
If the knee joint is ankylosed, this will preclude knee flexion during swing phase. Under these circumstances a compensatory device is essential so that the foot will clear the walking surface during swing. The most efficient method is called vaulting and it involves raising the trunk during each swing to clear the foot. Less efficient methods of compensation include circumduction of the leg or walking with the leg in an abducted position.

If the ankle is ankylosed, then there is loss of normal push off because it is impossible to plantar flex the joint. To compensate, the patient will pick up the foot by flexing excessively at the hip and knee and will place the foot forward flatly on the walking surface. Such a gait is characterized by its uneven timing.

### Unstable Supporting Muscle

When supporting muscles are weak, the gait becomes abnormal. A variety of these can occur but the most common involves weakness of the abdominal muscles. When this occurs, the pelvis drops anteriorly and it cannot be lifted. In effect this is analy-

FIGURE 7



gous to a hip flexion contracture. To compensate, the patient maintains a spinal column lordosis in order to see where he is walking. The gait is commonly described a steppage type.

A less common but important type of supporting muscle weakness involves paralysis of the gluteus medius muscle. Normally it holds the pelvis as level as possible. However, when it is paralyzed the pelvis drops on the swing side because it cannot be held down on the stance side. To compensate, the patient tilts his body to the stance side to maintain his equilibrium. A spinal column scoliosis develops and there is a drooping of the shoulder on the stance side.

### Painful Weight Bearing

Any pathological condition anywhere in the lower extremity which produces pain on weight bearing will produce a gait deviation characterized by uneven timing. During each stance cycle on the painful leg the patient shortens the period of weight bearing. He compensates by lengthening the period of time he bears weight on the normal leg.

It does not matter where the pathology exists. The gait deviation is the same no matter the site since the reaction by the patient is to reduce the length of time he must feel pain. However, the greater the degree of pain the shorter will be the length of stance phase on the painful leg.

### Weakness of Propelling Muscle

When propelling muscles are weakened the gait will also deviate. The type of the deviation is dependent upon which muscle group is abnormal. The more common

types will be described.

When the quadriceps muscle is paralyzed the patient loses control of knee extension. He compensates by bringing into action all other muscles which can extend the knee. These include the hamstrings, sartorius and some of the hip adductors. With these muscles the patient forces the knee joint into hyperextension and holds the joint in this position with his medial collateral, lateral collateral and cruciate ligaments. The hyperextended position resists gravity and the patient can bear weight without fear of knee collapse.

When the gastrocnemius muscle is weak, push off by the forefoot at the end of stance phase is impaired. The gait deviation which results is quite similar to a fused ankle gait. The patient places the foot forward in a flat footed manner without push off utilizing an increased amount of hip and knee flexion.

When the anterior tibial muscle group is paralyzed there is apt to be toe drag during the swing phase and foot slap at the beginning of stance. These abnormalities tend to reduce the patient's ability to walk without stumbling and this kind of a gait deviation is commonly seen in hemiplegic patients.

### Summary

An understanding of the basic mechanics involved in the production of a normal gait is essential in order to deal with the abnormal. A classification and a brief description of the common gait deviations have been presented. Using this information should enable the physician to accurately diagnose similar gait problems in his clinical practice. Rational methods of treatment should become readily apparent when the deviation cause has been discovered. ◀

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# One Year's Experience In A Small Community Hospital

BY HUGH S. ESPEY, M.D./QUINCY

The effectiveness of intensive coronary care in lessening the mortality of acute myocardial infarction has been proven by numerous reports. This new concept was first put into use by Day<sup>1</sup> and was further implemented by Meltzer.<sup>2</sup> The recent report by Day<sup>3</sup> on five years' experience of intensive coronary care gives a complete evaluation of this subject.

An analysis of our first year's experience in the intensive care of acute myocardial infarction is felt to be of sufficient interest for reporting, particularly since we have no house staff. We have trained our nursing staff and the program was "started from scratch."

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**FACILITIES:** This study reports the experience at Blessing Hospital, a 238-bed general hospital. The Intensive Care Facility has a total of eight beds, located in three connecting rooms with a central nurses' station. Four of the beds are equipped with wall-mounted electrocardiogram monitoring units and at the nurses' station are electrocardiogram monitors, rate meters, and electrocardiogram write-out. Our use of the term "Coronary Care Unit" actually means the Intensive Coronary Care Section as part of the Intensive Care Unit.

**ADMINISTRATION:** The Department of Internal Medicine (six internists) with the aid of the Nursing Department and Hospital Administration assumed the initiative in planning the administration of the Unit, recommending hospital policy and training the nurses. Certain emergencies were defined and after many hours of instruction to the Nursing Staff, authority has been given to institute emergency treatment when indicated. These procedures were felt necessary inasmuch as there may be many hours each day when no physician is at hand.

**RESULTS:** After 12 months, all cardiac cases treated in the Coronary Care Unit

were reviewed as well as cases of myocardial infarction treated elsewhere in the hospital. It immediately became apparent that many of the cases treated elsewhere in the hospital and diagnosed as myocardial infarction actually did not show sufficient diagnostic criteria to justify such diagnosis, and of the 50 case records that were found to have this diagnosis, only 30 were accepted as having the diagnosis justified.

The criteria for the diagnosis of acute myocardial infarction were: (1) a clinical picture consistent with that diagnosis; (2) electrocardiographic evidence; (3) transient elevations in the serum enzymes (CPK, SGOT, HBD, and LDH). In cases where a Q-wave did not develop in the electrocardiogram, the diagnosis was based on changes in the ventricular conduction complexes (S-T segment deviations and previously upright T-waves becoming inverted) together with elevation of the serum enzymes. The enzymes were tested daily for three successive days in all cases. Fever not due to a cause other than myocardial infarction, drop in blood pressure and the clinical course were given some consideration as factors of lesser importance in establishing the diagnosis.

**Table I**  
**Acute Myocardial Infarction**  
**(9-1-66—8-31-67)**

	Treated ICU	Treated Elsewhere
Total	77 cases	30 cases
Recovered	60 cases	19 cases
Died	17 cases	11 cases
Mortality Rate	22.0%	36.6%

Table I gives a comparison between cases of myocardial infarction treated in the Intensive Care Unit and those treated elsewhere. Of the 107 cases warranting this diagnosis in one year, 77 were treated in the Intensive Care Unit and 30 elsewhere. The mortality rate of those treated in the Intensive Care Unit was 22.0% and that of those treated elsewhere was 36.6%.

Table II shows an analysis of the cases treated in the Coronary Care Unit in one year. This consists of cases of myocardial infarction, suspected myocardial infarction, and other major cardiac problems. There were 124 admissions, of which 77 were proven cases of myocardial infarction. There were an additional 27 cases that on admission were suspected as possibly representing myocardial infarction but actually

**Table II**  
**Total Cardiac Cases Treated In ICU In One Year**  
**(9-1-66—8-31-67)**

AMI—Proven Cases	77
Admitted Suspect AMI, Proven Otherwise	27
Other Cardiac Diagnoses	20
	<hr/>
	124

**Final Diagnosis—Cases Admitted As Suspect AMI But Proven Otherwise**

ASHD with Coronary Insufficiency or Angina Pectoris	8
Gastrointestinal Disease	5
ASHD with Congestive Heart Failure	3
ASHD—Ancient AMI	3
Neurosis	3
Hypertension and Chest Pain	2
ASHD—Syncope of Undetermined Cause	1
Irritable Heart Syndrome and Anemia	1
Pulmonary Emphysema	1
	<hr/>
	27

**Other Cardiac Diagnoses**

ASHD—3-degree AV Block—Adams Stokes Syndrome	5
ASHD—for Elective Cardioversion	3
ASHD—Paroxysmal Arrhythmia	3
ASHD—Congestive Heart Failure	2
Paroxysmal Arrhythmia	2
ASHD—Ancient AMI—Hemorrhage from Anticoagulant	1
Syncope—Cause Undetermined	1
Malfunction of Pacemaker	1
Adjust Pacemaker Amplitude	1
Post Myocardial Infarction Syndrome	1
	<hr/>
	20

were found to have another type of diagnosis. Twenty cases had other diagnoses.

It is of interest to note that there would have been a much larger number of admissions to the Coronary Care Unit had all cases of proven and suspected myocardial infarction been admitted. It is estimated that if all such cases had been admitted to the Coronary Care Unit, the total number of admissions would have been at least twice as great. A high degree of suspicion is essential, for the suspected case of myocardial infarction may be the very one who has the greatest need for the facilities offered by such a Unit.

Table II lists the general categories of the cases that were on admission suspected of myocardial infarction, and the final diagnoses represent quite a variety.

In the category of "other cardiac diagnoses" the majority of admissions were the result of arteriosclerotic heart disease.

**Table III**  
**Fatal Cases**  
**Length Of Survival**

	Treated ICU	Treated Elsewhere
1 day	6	2
2 days	2	3
3 days	3	2
4 days	0	0
5 days	0	0
6 days	1	0
7 days	2	1
8 days	1	0
9 to 12 days	0	3
13 plus days	2	0
	17 cases	11 cases

**Table IV**  
**Cases Of AMI—By Age And Sex (Mortality)**  
**Cases Treated ICU**

Age	Male	Female
81 - 90	1 (1)	4 (2)
71 - 80	8 (4)	5
61 - 70	17 (4)	4 (2)
51 - 60	23 (4)	3
41 - 50	10	—
Under 40	2	—
	61 (13)	16 (4)

**Cases Treated Elsewhere**

Age	Male	Female
81 - 90	2 (2)	—
71 - 80	5 (2)	4
61 - 70	5 (3)	4
51 - 60	5 (1)	2 (1)
41 - 50	—	1 (1)
Under 40	2 (1)	—
	19 (9)	11 (2)

(The number of fatal cases is shown in parentheses.)

Table III shows that the greatest mortality occurs in the first few days in the cases of hospital-treated myocardial infarction. It has been our policy to keep individuals in the Coronary Care Unit for five days after they have shown no unfavorable reaction. The record shows four deaths between the fifth and eighth days, indicating that perhaps a longer period of observation is warranted.

Table IV shows the breakdown of cases by age and sex. The most interesting feature is the difference in males treated in the Unit as contrasted with those treated elsewhere. Those treated in the Unit showed 13 deaths in 61 cases (21%) and those treated elsewhere showed 9 deaths in 19 cases (47%).

**Table V**  
**Major Complications Of AMI (ICU)**

	Total	Expired
Congestive Heart Failure	8	5
Shock	10	10
Cardiac Arrest		
Vent. Fibrillation	3	2
Vent. Asystole	3	
Post Infarction Syndrome	1	
Rhythm Problems		
Frequent VPC	16	
Parox. Aur. Fib.	3	
PAT	2	
Vent Tac	1	
3rd degree AV block	2	

Table V shows the major complications encountered in acute myocardial infarction, there being eight cases of congestive failure, ten of shock, and six cardiac arrest. Five of the eight cases of congestive heart failure, all ten cases of shock, and two of three cases of ventricular fibrillation expired, accounting for the 17 total deaths.

One case of post-infarction syndrome and 24 severe rhythm disturbances comprise the other major complications. Those cases of rhythm problems which are tabulated here represent the only major problem in these



particular cases. In other words, this does not include cases of congestive heart failure or shock who showed rhythm disturbances. We see that frequent ventricular premature contractions were relatively common, occurring in approximately 1/4 of the cases. Usually this would represent either a bigeminy or trigeminy rhythm or at least five ventricular premature contractions per minute. Paroxysmal auricular fibrillation, paroxysmal auricular tachycardia, ventricular tachycardia, and third-degree AV block comprise the other major rhythm problems. It is of considerable interest that almost without exception these cases responded satisfactorily to prompt and aggressive management.

**Table VI**

**Arrhythmias In AMI (ICU)**

Ventricular Premature Contractions	44 (57%)
Auric. (Supravent.) Premat. Contr.	19 (25%)
Sinus Tachycardia	16 (21%)
Sinus Bradycardia	16 (21%)
Auricular Fibrillation	12 (16%)
Paroxysmal Auricular Tachycardia	4 (5%)
First-Degree AV Block	4 (5%)
Third-Degree AV Block	4 (5%)
Second-Degree AV Block	3 (4%)
Paroxysmal Ventricular Tachycardia	3 (4%)
Auricular Flutter	1 (1%)
Sinus Arrest	1 (1%)

Many cases are found to have multiple arrhythmias.

**Table VII**

**Arrhythmia In AMI (ICU)**

	No. Cases	Expired
No Arrhythmia	14 (18% of cases)	1
Any Arrhythmia	63 (82% of cases)	—
More Serious		
Arrhythmia	23 (29% of cases)	12 (70% of fatal cases)

(Does not include SB, ST, VPC, APC)

In Table VII, the relationship of arrhythmia to mortality is shown in a rather rough way. Of the 14 cases that showed no arrhythmia, only one expired. This chart shows that 82% of cases studied had some type of arrhythmia. It is to be pointed out that the diagnosis of arrhythmia is made only when the rhythm was either seen on the oscilloscope or when it was recorded on the permanent electrocardiogram write-out. It has been our habit to make permanent records only at specified periods. We have not had a memory loop attachment to our equipment. Therefore, unless certain arrhythmias were of sufficient degree to activate the automatic write-out by violating the given pre-set rate limits or unless the patient's record was actually being

viewed at the time of arrhythmia, this disturbance in rhythm would not be recorded and it is quite likely that a number of minor arrhythmias and perhaps even transient major arrhythmias might have escaped detection. With this degree of surveillance we found 82% of all cases had a demonstrable arrhythmia; if we exclude sinus bradycardia, sinus tachycardia, ventricular premature contractions, and auricular premature contractions, we find that there were 23 of the 77 cases that showed what might be called more serious arrhythmias, representing approximately one-third of the cases. In this group of 23 cases, we find 70% of all deaths and it is obvious then that certain arrhythmias which we have called "more serious" carry a more grave prognosis.

**Table VIII**

**Classification Of Cases**

- Class I. No evidence of hypotension, shock, or congestive heart failure
- Class II. Either congestive heart failure or mild hypotension, but no shock
- Class III. Cardiogenic shock

Table VIII is merely the explanation of the way in which cases were classified on admission as to severity, Class I being the least ill and Class III being the most severely ill.

In the year that was studied, there were 77 cases of proven myocardial infarction treated in the Coronary Care Unit and 30 cases in which the diagnosis of myocardial infarction was reasonably certain treated elsewhere in the hospital. Had we included the full number of cases in which myocardial infarction was the final diagnosis on the chart, the mortality would have been much greater in those treated elsewhere in the hospital.

All of these cases are analyzed according to severity and are classified as to Class I, II, and III. Only one of the 46 Class I cases treated in the Coronary Care Unit died, whereas five of the Class I cases treated elsewhere in the hospital died. In other words, the mortality rate was 2% in this class of cases treated in the Coronary Care Unit and 25% when treated elsewhere in the hospital. The one case that expired while being treated in the Unit entered in this category but subsequently developed varying degree of heart block and later shock. As we review the cases in the Class

**Table IX**  
**Treated In ICU**

	Total	Expired (Mort. %)
Class I	46 cases (60%)	1 case (2%)
Class II	23 cases (30%)	9 cases (39%)
Class III	8 cases (10%)	7 cases (87%)

**Treated Elsewhere**

	Total	Expired (Mort. %)
Class I	20 cases (66%)	5 cases (25%)
Class II	8 cases (27%)	4 cases (50%)
Class III	2 cases (7%)	2 cases (100%)

II category, we see that there is a significant reduction in the mortality rate when those cases treated in the Unit are compared with those treated elsewhere.

It is felt that this small series of cases is of interest in pointing out the fact that acute myocardial infarction may be effectively treated by the means of intensive coronary care in the small community hospital without house staff, and the mortality rate may thereby be significantly lessened. As we have reviewed these cases, it is our feeling that the mortality rate in our second year should show a decrease from the

first year of operation. Also, it is felt this points out that facilities of this type are not necessarily to be reserved for the more seriously ill patient and it is hoped that aggressive treatment of minor problems in those people who are not ill will keep them from becoming more seriously ill, and perhaps not surviving. The fact that only 2% of the Class I cases died in the Coronary Care Unit, while 25% of those treated elsewhere in the hospital died, cannot be over-emphasized. It is our firm belief that all cases of proven or suspected myocardial infarction should be treated by this manner. ◀

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## **COLLEGE STAND ON ALCOHOL AND HIGHWAY SAFETY**

In a resolution adopted by the Board of Regents, the College has gone on record in support of all programs which might serve as a deterrent to people driving while under the influence of alcohol. The resolution reads as follows:

**WHEREAS**, the United States Department of Transportation has reported in a recent study, entitled "Alcohol and Highway Safety," that alcohol contributes to about 25,000 of the approximately 53,000 fatal highway injuries in the United States annually; and

**WHEREAS**, scientific investigation has conclusively established that driving skills deteriorate rapidly as consumption of alcohol increases; and

**WHEREAS**, careful studies clearly show that the higher the concentration of alcohol in the blood of a person driving an automobile, the greater the likelihood that: 1. He will crash; 2. He will have initiated the crash; and 3. The crash will be severe; and

**WHEREAS**, Fellows of the American College of Surgeons in their surgical practices continually witness the human suffering and destruction resulting from serious automobile accidents caused by the excessive use of alcohol; and

**WHEREAS**, reports from several states and abroad indicate that educational programs and measures such as implied consent laws, requiring a motorist suspected of being under the influence of alcohol to submit to a "breath test" and/or tests of his blood alcohol level or forfeit his driver's license, have led to reduced incidence of fatalities and serious injuries from street and highway crashes,

**NOW, THEREFORE, BE IT RESOLVED**, that the Committee on Trauma of the American College of Surgeons recognizes the serious dangers inherent in the immoderate use of alcohol before driving, and urges all motorists to refrain from consuming alcohol before driving,

**BE IT FURTHER RESOLVED**, that the Fellows of the American College of Surgeons are urged to support implied consent laws and other programs and policies designed to reduce the incidence of driving by persons while under the influence of alcohol,

**BE IT FURTHER RESOLVED**, that the Committee on Trauma recommends that the Board of Regents approve this action and publish it as a policy of the College.

# The Coronary Care Unit In A Non-Teaching Hospital

By R. F. HERNDON, M.D., AND PAUL SMALLEY, M.D./SPRINGFIELD

*Communications in Medical Journals encourage Coronary Care Units in non-university centers.<sup>1,2</sup> Our community has such a unit. We will describe a year's experience with such a facility.*

*Monitoring equipment has been in use and a program of education for nurses has been in operation. The unit is supported by a panel of physicians who act in one or both of the following capacities: There is a panel of "on call" physicians who provide emergency care if the patient's attending physician is either unavailable or unable to render such care; secondly, there is a consultant panel of all the above emergency panel and the remainder of internists who consult in heart disease. Consultation is obligatory. The emergency panel provides emergency coverage and consultation without fee.*

*Records have been maintained in the usual fashion. Our experience follows:*

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Paul E. Smalley, M.D., is a Springfield clinical cardiologist, who along with Dr. Herndon, was instrumental in establishing a Coronary Care Unit in Springfield four years ago.

In the year before the use of the Coronary Care Unit and its equipment, we observed a gross in-patient mortality of 35.4% from arteriosclerotic heart disease with acute myocardial infarction. In the period with the unit established:

(1) We had 142 patients with acute myocardial infarction; 112 survived, 20 of these died in the unit in less than four days observation, 10 died after five or more days (See Table I), an inpatient mortality of 21.3%.

(2) We had 178 patients with heart disease but without recent infarction; 167 survived, 11 died. Six deaths of these 11 were cardiac, five of unrelated causes.

(3) We had 47 admissions, not later found to have heart disease.

(4) 34 patients with acute infarction received external countershock; 20 of these 34 survived.

(5) Electrical pacing was uncommon in the 142 acute infarctions, four patients were so treated. Pacing was commonly unsuccessful, 3 died.

Our results are comparable to that of other units.<sup>3-5</sup> Our statistics support the view that Coronary Care Units may be established, staffed and operated in non-teaching institutions without a house staff. Continuing education for nurses is essential. We report a reduction in in-patient mortality from 35% to 21%. ◀



TABLE I

Total infarcts	142	
a. Deaths	30	
(1.) Under 4 days	20	14.2%
Shock	13	63%
Heart failure	3	16%
Rupt. Myocard.	1	5%
Unresponsive to ECT	3	16%
(2.) Over 4 days	10	7.1%
Heart failure	5	50%
Pul. Embolus	1	10%
Unresponsive to elect. countershock	2	20%
Failure to pace	2	20%

### References

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### Homes For Aged

The major crisis for people in a home for the aged comes within the first six months of entering the institution, according to Morton A. Lieberman, Associate Professor of Psychiatry in The Pritzker School of Medicine and in the Committee on Human Development at The University of Chicago.

Figures in a recent study conducted by the University show that of 1,000 persons institutionalized, 24 per cent died within the first six months, whereas only 10 per cent of those awaiting entrance into institutions but still living in a community setting died during the same six-month period.

Lieberman added that in addition to the 24 per cent who died within the first six months, approximately 25 per cent of the others had serious physiological or psychological problems.

However, those old people who pass the six-month mark, Lieberman said, "appear to be as well adjusted as similar old people within the general community."

He indicated, therefore, that support and encouragement are needed most in such institutions during the first half year to help the aged past the crisis.

One of Lieberman's conclusions is that much more ought to be done in working with old people before they enter an in-

stitution. As much as a year before the actual act, they should start preparing for it.

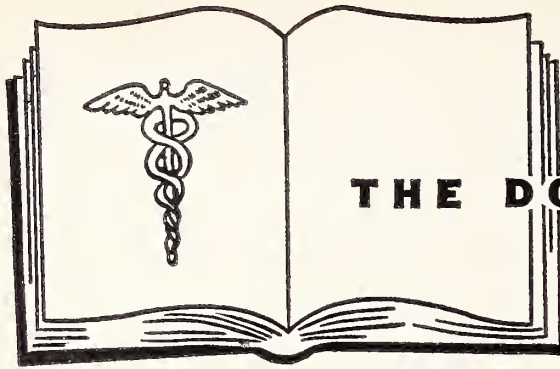
This preparation, he cautioned, should be basically realistic. Denying that the event will take place or seeing it as a joyous prelude to heaven are equally dangerous.

Lieberman's studies began with the desire to find out what kind of person does not adjust to the life crisis situation of institutionalization.

Through extensive psychological testing, interviews, and examination over several years, Lieberman and his colleagues began to examine various long-standing hypotheses about vulnerability. Many proved false.

First they found that the number of major life crises a person had faced and his previous ability to adapt to crises was no great indication of how he would react to institutionalization. This was true of all but those old people with the very lowest intellect and capacity to adapt.

Lieberman also found that hope was an important factor in weathering the crisis of institutionalization. Old people who can project into the future and can talk about positive future events in which they will be involved, such as the wedding of a granddaughter, are likely to adapt.



## THE DOCTOR'S LIBRARY

**THE PRINCIPLES AND PRACTICE OF MEDICINE.** Seventeenth Edition. Edited By A. McGehee Harvey, M.D., Leighton E. Cluff, M.D., Richard J. Johns, M.D., Albert H. Owens, Jr., M.D., David Rabinowitz, M.D., and Richard S. Ross, M.D. with 59 contributors. 1968. Appleton-Century-Crofts, Div. of Meredith Corp., New York, New York. 1,472 pages. Illus. \$22.50.

As a Johns Hopkins textbook of medicine envisioned by William Osler, six editors and 59 contributors have produced an entirely new **PRINCIPLES AND PRACTICE OF MEDICINE** and designated it as the 17th edition in tribute to Osler's classical text. Yet it attempts neither his individual approach nor his comprehensive coverage. Still it supplies the student with a manageable textbook that a teacher could reasonably expect him to complete during a course in clinical medicine.

As the work of the faculty members of one medical department, the new book will help their students best. However, the text shows seasoned judgment that makes it easily adaptable for use elsewhere. Focusing directly on the patient, the editors have designed their book to answer three questions: What is the matter with the patient? What can I do for him? What will be the outcome? The first section of the book considers how to approach, to interview, to examine, to use the laboratory and x-ray, to diagnose, and to manage the patient. The book continues with disorders of metabolism, diseases of the main organ systems, immunologic disturbances, psychiatric problems, genetics, specific complications of medical management, and the handling of medical emergencies.

The book is well written, nicely printed, and sturdily bound. While it is designed for

students, it may also serve the practicing physician when he feels the need to restore his broad perspective of internal medicine. It is not particularly suitable as a reference for obscure details of illness so often sought in a hurry during busy practice.

William H. Wehrmacher, M.D.

**TIME FOR DYING.** By Barney G. Glaser and Anselm L. Strauss, 270 pages, Aldine Publishing Co., Chicago, 1968, \$6.95.

Glaser and Strauss are sociologists stationed at the University of California Medical Center, San Francisco. They obtained their information from hospitals in the Bay Area and at 10 other hospitals in Greece, Italy, and Scotland. They had the cooperation of the staff and personnel who cared for the dying patient. The book is oriented toward making the management of dying more natural and compassionate.

Most physicians and nurses are taught the technical aspects of terminal illnesses, but they must learn the important psychologic and sociologic aspects. Through experience we learn (or neglect to learn) how to communicate with the patient and the family; and how to handle, with finesse, the stages that terminate in death. The authors note that the staff's reactions vary considerably at the critical times. Most of us continue to treat life's end unrealistically and, consequently, this is reflected in our behavior. A ritual is superfluous if death is natural, but when it is not natural, set standards cannot be established. Both men are of the opinion that much needs to be done to make dying natural and, when death is inevitable, to include, and not isolate the patient.

T. R. Van Dellen, M.D.

# Psychiatric Aspects

of the

## Rehabilitation of Geriatric Patients

BY JACK WEINBERG, M.D./CHICAGO

Aging is a process of change involving all aspects of the organism, but not necessarily occurring in an interrelated or synchronous fashion. Old age is a period in the aging process characterized by rapid, profound and multiple changes of varying intensities, physiological and social, which influence subjective experiences, behavior and adaptation. Clarification of the nature of these changes and their age specificity is exceedingly difficult, for chronological aging is imbedded in a matrix of multiple factors ranging from the physiological to the social organization. It is, of course, of fundamental importance for the therapist of the geriatric patient to first determine the degree of disease, particularly arteriosclerosis, sensory deficit and social deprivation present in those whom they are about to treat. For findings of many studies

suggest that many manifestations, heretofore ascribed to aging per sé, reflect instead, medical illness, personality variables and social-cultural effects.

In the care and treatment of the aged, the psychiatrist may have his own set of expectations and set goals in concert with them. The patient, his family, and the community have their own goals and expectations of the psychiatric experience. For the psychiatrist, the goal is usually to work for the maximum possible restoration or preservation of function with minimal injury or distress to patients and environment. His efforts should be directed toward the decrease of suffering, augmenting of function, increasing productivity and a decrease of interpersonal disturbance. From the standpoint of the family, the primary expectation is usually that its own distress, either from injury inflicted upon it by the patient, or from observing the patient's distress or disability, is relieved. The community's prime concern is its own protection and survival. The patient usually hopes that the psychiatrist will relieve his uncomfortable symptoms and alter the environment to suit him. Mingled with this hope is a fear that the psychiatrist may find him ill, disturbed and committable.

### Three Criteria

The physician dealing with the clinical problem of the aged must keep certain criteria in the foreground of his thinking if his judgment, and, consequently, his therapy, are to be correct and effective.

1. Man, no matter what his age, is heir to any of the disease processes that or-

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ganic matter is susceptible to in its attempts at adaptation. Neuroses, therefore, can and do make their appearance with astonishing frequency in later life.

2. The understanding of the psychological disease entities in old age depends, as it does in any age, upon the knowledge and understanding of the premorbid personality structure and its historical development. For whether the disease is organic or functional, the psychological picture will depend not so much on the site of the lesion as on the premorbid character structure.

3. All symptom formation has inherent in it a protective quality. The first two criteria are self-explanatory; the last needs further amplification.

Physicians are wont to look upon symptoms as undesirable phenomena, signs that something has gone wrong within the organism in its quest for homeostatic equilibrium, something to be "rid of." However, one must not lose sight of the fact that symptoms have a function to perform that is often useful and protective in nature. As psychiatrists, we conceive of all symptoms as defense maneuvers on the part of the ego in its attempts at adaptation to an ever-changing internal and external scene. Psychologically, one is really afraid of only one disease; the dissolution of one's ego, character or problem solving boundaries, with a subsequent loss of identity, intactness and oneness. It is to guard against such an eventuality that pathologic defenses in the form of symptoms appear as last-ditch efforts against a complete break.

The ego, of course, is that institution of the personality which perceives internal and external stimuli, integrates them, and allows for unified action. It is the compromiser between our instinctual drives, our appetites and hungers, with all of their irrational demands upon the organism, and the moral, ethical and cultural forces which are opposed to the chaotic expression of these drives. It is the ever-watchful, alert guardian whose job it is to protect the individual against utter and complete dissolution in the face of whatever vicissitudes may befall him. Furthermore, it is its function to maintain a psychic homeostasis which it will do at all costs short of a psychosis. Yet, even in the latter, it attempts to restore order where order, as the normal

person sees it, is lacking. The more flexible and plastic the ego, the more integrated the individual's behavior. Added to the above, it is good to remember that the ego may be flexible in certain areas of adaptation and rigid in others. Thus, one may be able to adjust and change with the times in a vocational choice and yet be rigid and stereotyped in the social outlook.

### Ego Function

Adequate ego function is dependent on a number of factors. Freedom from physical disease or crippling greatly enhances the chances for good adaptation, for the less the organism is disturbed by pathologic stimuli, the more ego energy is available for external adaptation. The converse is true for the phenomenon of loss of interest in the outer world and what goes on about one, when one is ill. Furthermore, the ego's proper functioning depends on the element of hope. A man will endure the greatest pain if he has the hope that eventually the suffering will come to an end or that the future will be brighter. The child who gives up many of his dependent gratifications for responsible achievement does so out of the clear knowledge that not only will his own concepts of what he is to be like be met thereby, but also because of the fact that every progressive step will bring approval and love from his parents or the meaningful people about him. Approval and love from others, the yearning for them and the hope for their realization, are important ingredients in a person's drive for the maintenance of the self. Since this hope diminishes with age, since the hope for a better tomorrow is a mirage in the twilight of life, the danger to the psychological balance of the organism is great. The imbalance is augmented by the fact that the aging process diminishes the energy reservoir available to the ego and that organ destruction within, increasingly and disproportionately, forces man to look inwardly to internal pathologic symptoms.

The threat of organ destruction within plus the welling up of heretofore unacceptable but controlled impulses and the deterioration of the individual's socio-economic status tax the adaptive capacities of the ego to the utmost. What emerges is the frightening and unacceptable specter of loss of mastery over one's own physical

self and behavior, as well as the loss of mastery and influence over one's environment, i.e. family and community.

To master the threat of dissolution of its boundaries and to ward off any break with reality, the adaptive capacities of one's character will go through all sorts of contortions in symptom or defense formation. The symptoms that arise with aging have a uniqueness characteristic of that period in our life. They indicate that there is a waning of power and they tend to indicate that the organism is trying to maintain itself by giving up certain powers in order to maintain or preserve others more essential to its unity. In general, the symptoms that form in later life may be divided into three categories: exclusion of stimuli, conservation of energy, and regression. The defense maneuvers of conservation of energy and regression are fairly clear and have been dwelt upon by many others. I would like to explain, however, what I mean by the exclusion of stimuli, a very common defense in later life which most physicians usually ascribe to organic changes.

### **Exclusion of Stimuli**

I have stated before that it is the function of the ego to perceive and integrate internal and external stimuli. Since the aging process curtails one's capacity to deal with the multitude of stimuli that clamor for attention in our complex society, the organism begins to exclude them from its awareness. This may best be illustrated by the following example. We often hear someone make the remark, "My grandmother doesn't see too well, but what she shouldn't see, she sees only too well." Or "My father doesn't hear too well, but that which he shouldn't hear, he hears all right." A remark of this sort is really an observation which can be classified as being scientific in nature. It implies that the afflicted individual is capable of selection and that the defect is not really organic. For were it organic in nature, the person suffering from it would probably be unable to hear a particular tone or to see in a particular direction. However, organically affected organs do not exclude certain ideas and permit others to pass their perceptive threshold. It is my conviction that the aging organism, having at its disposal a

lowered psychic energy supply and being unable to deal with all stimuli, begins to exclude them. This is true of all sensory stimuli except possibly for those of the olfactory nerve.

The infant also is faced by the same overwhelming stimuli with little ego development to help it cope with them. However, the very young can and do take refuge in sleep to allow for a gradual exposure to the clamor and the integration of it. Then, too, they have the help of supportive figures who are ever ready to supply ego judgment and strength to the struggling new organism. Both of these elements are not available nor are they acceptable to the aging organism; hence, the exclusion.

Though it may be argued by some that the mechanism of exclusion of stimuli is identical with the familiar mechanism of denial, it is my feeling that it is quite different. Denial to me implies that a stimulus has been perceived, has been cathected to and invested in, with cathexis being then withdrawn. But exclusion of stimuli, in this instance, is an unconscious blocking out of stimuli with an investment of energy only in that which becomes emotionally pertinent.

### **The Psychiatrist's Role**

To meliorate the arising pathology, the psychiatrist's role is a triple one. The first is his relationship with the patient. In 1951, I stated it as follows: "From time immemorial man has struggled with the irrational forces underlying emotional disturbances. Everything conceivable has been tried by those who have been called upon to treat human beings. Psychiatrists have come a long way from the days when, through incantation and prayer, man tried to placate and drive out the evil spirits. We have attempted brain surgery and shock treatment, long-term psychotherapy, short-term therapy, individual psychotherapy, group-therapy, various drugs, heat and cold, fire and ice, music, socio-drama, hydrotherapy, occupational and recreational therapy, total push to total regression; all have been tried, and to all have been ascribed healing powers by those who promulgate their favorite means."

"The confusion resulting from all of the claims becomes no confusion when one realizes that all of the above therapies



have a common denominator. The common denominator is, of course, the therapist and the patient, the interpersonal relationship between them. . . . For no matter what the treatment may be (and there are, of course, valid and intrinsic values in all of the above named methods), it is nonetheless the awareness on the part of the patient that in the therapist he has an individual who is ready to understand, willing to give and to help, which is beneficial."

What I said then holds true today and certainly coincides with the thinking and experience of many clinicians. All recognize the enormous importance of the relationship and the role played by the psychiatrist. The need is for an enthusiastic, optimistic approach which is genuine, an active participation in the relationship which depends as much on its quantitative aspects as it does on the evaluation of its quality. The psychiatrist working with the aged must free himself of his feelings of being bound by formalistic approaches to therapy. He must be willing to venture out and try out modifications of traditional techniques. Certainly, the psycho-analytically-trained psychiatrists, who have reported on their therapeutic success with the aging, cited their more active role, were ready to do away with the couch and allowed themselves to enter more freely into a relationship with the patient.

Second, the psychiatrist must be aware of the nature of the pathology. The outstanding characteristics of senescence which threaten emotional health are physical decline, loss of erotic values, loss of supportive figures, social and economic insecurity and the gradual contraction in the flexibility and plasticity of the adaptive mechanism. The decrement in personal, physical and emotional assets and the absence of hope (a vital ingredient for ego integration) for a better tomorrow greatly endanger the adaptive capacities of the ego. To master the threat of dissolution of its boundaries, the ego will utilize all of its previously learned defenses and add some new ones to its repertory. The major defenses employed by the ego in later life are those of regression, rigidity and the exclusion of stimuli.

### Principle of Defense

Regressive symptoms are easily discernable phenomena and I need not elaborate upon them. However, few recognize in rigidity the dynamic principle of a defense. We live in a highly complex, ever changing world demanding of us constant readaptation. To master new situations requires the greatest efficiency and integration of the ego. The decreased efficiency of the ego in the elderly almost always calls forth anxiety when readjustment is necessary. To avoid anxiety the aging person will cling to automatized and familiar patterns of behavior no matter how faulty they may be. He reacts to new situations as to some danger with peevishness, irritability and hostility. Change is regarded with paranoid suspicion and fear, and the individual will cling to behavior which has heretofore given him the nearest approach to mastery of his environment. This, then, is the familiar conservatism of the aged.

The third defense maneuver of the aged, which may be called upon first, is the exclusion of external stimuli, which, by their confusing diversity, may upset the homeostasis of the psyche as set up by the ego. This is particularly true of the sensory system. The diminution of visual and auditory acuity in the aged are notable examples. Yet, there is something selective about the two, which can be explained only on the basis of the exclusion of some stimuli when energy to perceive, interpret and cope with new stimuli is at a low ebb. And, as I have indicated above, exclusion of stimuli seems to me to differ from denial.

All of these defenses are dynamic mental processes rather than fixed habit patterns with organic substrata, and are therefore not beyond therapeutic reach. The therapeutic goal, then, is first to understand the symptom, then to modify, alternate or work for the acceptance of some of them without resigning necessarily to further deterioration.

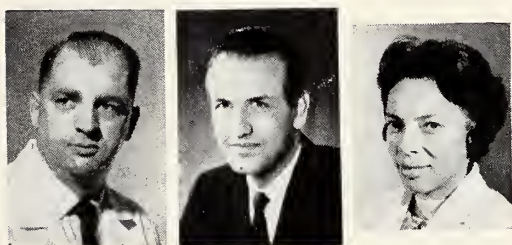
Lastly, it is the therapeutic function of the psychiatrist to manipulate the environment in which the older person lives. This may range from the education of the family, friends and those who are entrusted with the care of the aged as to the needs of the patient and the meaning of the symptoms, to a dogged gnawing at the conscience of society for a better emotional climate for our aging population. ◀



# Community Child Care

## *The Role of the Neighborhood Health Center*

BY JOSEPH R. CHRISTIAN, M.D.,  
ALBERT L. PISANI, M.D.,  
AND IRIS SHANNON, R.N./CHICAGO



Albert L. Pisani, M.D., (left) is Chief of the Section of Ambulatory Pediatric Services, Presbyterian-St. Luke's Hospital, Chicago. He received his M.D. from Loyola University, Stritch School of Medicine, and served his residency at Mercy Hospital. He is certified by the American Board of Pediatrics and is a Fellow of the American Academy of Pediatrics. Dr. Pisani is also an Assistant Professor of Pediatrics, the University of Illinois College of Medicine. Joseph R. Christian, M.D., (center) is Chairman, the Division of Pediatrics, Presbyterian-St. Luke's Hospital. He served his residency in pediatrics at Cook County Hospital and has taken postgraduate training at Harvard's Children's Hospital. Dr. Christian is Professor of Pediatrics at the University of Illinois College of Medicine. Iris Shannon, R.N., is a Director of Community Nursing, the Milk Square project, and has specialized in Public Health Nursing. She is a graduate of Fisk University and has an M.A. from the University of Chicago.

*The decade ahead will reveal how well we have managed the many crises which face this state and this nation: the poverty crisis, race crisis, hard core unemployment crisis, and the health crisis—all the related crises that make up the so called "Urban Crisis." This presentation will be concerned with the health crisis, more specifically the crisis in Child Care.*

*Our medical schools and teaching hospitals must develop new ways of bringing their resources to bear on the urgent health problems of our cities. These institutions have to get away from their woefully inadequate traditional approaches and remedies to the health crisis with which we are faced, a crisis so serious that it is termed by many a "National Disaster."*

*It is mandatory that new approaches to the delivery of health care be created. The development of the Neighborhood Health Center represents one such new approach to comprehensive family-orientated medical care for poverty areas.*

The objectives of the Neighborhood Health Center are to establish (within the administrative framework of a teaching hospital) specifically trained teams of medical and paramedical personnel who can provide within a designated community comprehensive, coordinated and continuous medical care.

The Neighborhood Health Center emphasizes family-orientated services, both professional and supportive; thus the Neighborhood Health Center is more than just a health center. The Health Services frequently serve as an entry point for an attack on the other problems.

In order to effectively serve the needs of a community certain fundamentals must be considered in development of a medical care program.

1. *Initiation.* The most outstanding characteristic of disadvantaged groups is their *inertia* or *inability* to *initiate* the search for aid. Failure to appreciate this has been the primary reason why many programs designed to offer medical care to these groups has failed. This may be obviated by a community-orientated "Reach-Out" program which can motivate the individual as well as the group to avail themselves of the available preventive and therapeutic services.

2. *Continuity and Coordination.* In-patient as well as ambulatory services must be made available. Most health facilities offer fragmented, uncoordinated and episodic care. Failure to continue and coordinate the care of the patient when hospitalization is needed represents medical abandonment. For this reason the Neighborhood Health Center must be affiliated with a hospital, and the staff must have admitting privileges and the final say-so on whether or not to admit patients. This requires that funds be available for such hospitalization and that the sponsoring institution live up to its agreement.

3. *Completeness.* All services must be available; preventive care, therapeutic care, rehabilitation, extended care. This is a notably deficient aspect of many medical care programs, even though the institutions may have the most advanced and most recent therapeutic modalities perfected by scientific and technical developments.

4. *Family-Oriented.* The program should be family-oriented. Facilities and services should be available to take care of ALL

members of the family. Thus, the center should make available care in medicine, obstetrics-gynecology, family planning and mental health. It is noteworthy that in poverty groups as well as middle-income groups, parents invariably are much more likely to seek care for their children than for themselves, unless family care is readily available.

5. *Availability.* The Neighborhood Health Center should serve a defined area and should be located where there are large areas of low income persons, preferably not more than 25,000 persons per center. The center should be so situated that patients may walk to the center, and the community health nursing team may walk to the residents' homes.

6. *Permanence.* It is cruel and morally irresponsible to develop meritorious programs and then abandon them in the process of political reshuffling.

### Echelons Of Child Care

Echelons of care must be well organized and defined in order to provide personal and continuous care to the patients.

The first echelon of care is represented by the Community Health Nursing Team consisting of the Community Health Nurse (public health nurse) and the Community Health Aides. This team makes home visits in order to evaluate the health needs of the family, follow-up morbidity and to serve as health counselor and coordinator for the family.

The Community Health Nursing Team representing the first echelon of care will be inundated with families having complex health, social and emotional problems. Persons living in areas of deprivation have long had to endure fragmented, uncoordinated, ineffective, impersonal health services usually sought and offered on a short term basis.

Professional personnel must be sensitive to the sociological, anthropological and emotional factors which interfere with the patient's ability to accept and implement health instructions. The life styles of poverty groups result in a certain amount of separation from society. This demands an understanding of their attitudes, fears and suspicions in addition to providing for their basic health needs.

The Community Health Nurse functions as family health counselor. She evaluates

the home and financial, social, religious and environmental factors which affect the family. She contacts appropriate agencies on behalf of the patient.

The Community Health Aides, who have been recruited in the community and have been given basic health training, function as auxiliary health workers. They enhance the effectiveness of the program by sharing their expertise—the knowledge of life experiences in the community. They assist the professional nurse in carrying out elementary nursing procedures in the clinic or home. They render follow-up service to patients and families who have failed appointments or have difficulty keeping appointments. They review with families certain health education concepts such as dental health, accident prevention, food buying and credit, sanitation, housing problems and child care. The aides are extremely valuable in interpreting to families, services available to them through the Health Center; those available in the Community and those available in the city in response to identified health, environmental and welfare problems and further assisting the families in utilizing such resources when necessary.

The aides are also aware of the language of the community and can speak that language, eliminating a communication barrier. They can interpret physicians' orders in the language patients can understand, and can counteract old folklore and superstition that grandmother handed down to the younger generation.

It is essential that personnel who work in areas with many deprivations come to acknowledge the problem of how to effectively communicate with persons who have experienced chronic poverty and consequently developed feelings of exhaustion, fear, pessimism, isolation, defeat and who may have little ambition left. Unless we can communicate with the parents of infants in an effective manner, we cannot expect to meet the long term objectives of reducing the high mortality and morbidity rates which plague these areas.

### **Second Echelon of Care**

The second echelon of care is the Neighborhood Health Center. All routine ambulatory pediatric care is carried out here. Routine laboratory and X-ray facilities are available and a pharmacy is located on the premises. The emphasis in the center is on comprehensive, coordinated and continuous care. Every attempt is made to insure that infants and children are seen by the same pediatrician on each visit.

### **Third Echelon of Care**

The third echelon of care is the hospital facility. Ambulatory and in-patient consultative, diagnostic and therapeutic services must be planned in order to provide a program of complete service offering "Total Care" to all patients referred from the Neighborhood Health Center. Thus, beds must be available for admissions. All in-patients are assigned to the neighborhood health center service, and daily rounds are made by members of the Neighborhood Health Center's pediatric team. The center staff is available for consultation at all times.

### **Summary**

The aim of the Neighborhood Health Center is to improve the health care of poverty populations by making available comprehensive family-oriented health services within a designated neighborhood. The center is concerned with all aspects of health care including environmental, psychological and socio-economic. The availability of preventive, diagnostic, consultative and therapeutic services including home follow-up of minor and chronic illness enables the center to render 98-99% of medical care on an ambulatory basis. In addition to the anticipated decrease in morbidity and mortality as a result of these programs, some authorities have estimated that hospitalization rates can be reduced by 15% with their development. At the current rates of \$100.00 and up per day this becomes an increasingly important consideration. ◀

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**"You cannot strengthen the weak by  
weakening the strong."—Abraham Lincoln.**





**AN AMERICAN MELODRAMA:** The Presidential Campaigns of 1968, Lewis Chester, Godfrey Hodgson, Bruce Page, Viking Press, New York 1969. \$10

1968 was indeed a melodramatic year—a year of wonders, horrors and surprises. Recording that year and the complex and important presidential campaigns was a job undertaken by three young English newspapermen. Using the cooperative or “team” approach known as the “Insight” method, the authors have compiled a volume on one of the most exciting years in politics. The declared aim of the “Insight” approach is a “collective” view. Messrs. Chester, Hodgson and Page decided at the outset that a weakness of the traditional approach was the one-on-one coverage of major candidates—that is, assigning a reporter to each candidate and regarding him thereafter as the resident expert of all news from that quarter. All too often this type of reporter simply became the candidate’s ambassador to his newspaper and eventually, out of sheer boredom from having heard the same speech and seen the same demonstration once too often, the reporter missed the importance of what was going on. Not so with this triumvirate.

**AN AMERICAN MELODRAMA** is a candid appraisal of the presidential contenders. Much of the text centers on background data, both of persons and events, that enrich our understanding of the unfolding drama. We have again the old question: Do forces or men shape history? We see how a nagging war and the social unrest it produced, together with the possibility of humiliating political rejection, induced a weary President to announce his retirement from office; how that announcement affected the political ambitions of others; how the death of the Rev. Martin Luther King, Jr. incited riots, which in turn created a campaign issue—“law and order”—of unquestionable potency. The reader is made aware of the personal lives of the men who aspired to the Presidency and what motivated them to seek that office.

Not everyone will approve of everything

in **AN AMERICAN MELODRAMA**. Not everyone approves of politics. But it would not be a true reflection of political history if it satisfied every reader. For the most part, Wallace and Reagan supporters will be the most slighted. However, no one can fail to be absorbed by the insights into the American political process offered in the pages.

1968. The year that started as nothing exciting and ended as a real “cliff-hanger.” The year in which so many men of so many ideas came to the American public with a promise for a better America.

**AN AMERICAN MELODRAMA** has both the sweep of history and the immediacy of a daily newspaper. Don’t put off reading this fascinating panorama of the American Presidential campaigns of 1968.

**THE FUTURE OF AMERICAN POLITICS**, Samuel Lubell, Harper Colophon, New York, 1965. \$1.95

Samuel Lubell has written an intense study of the theory of U.S. politics. Now in its fourth edition, **THE FUTURE** is a must for all students of political science. Lubell has been a newspaperman, foreign correspondent, magazine writer, pollster, and White House Aide. He utilizes a unique “time machine” approach which allows him to see politics as a ceaseless struggle between the past and the future, and the electorate as the arena in which the struggle is taking place.

The strongest reason for the timelessness or timeliness of the book is the author’s ability to penetrate beyond the quadrennial candidates and analyze the basic forces which remake politics. Once having determined what those forces are, Lubell looks into the future.

**THE FUTURE OF AMERICAN POLITICS** covers politics from the Roosevelt era to the 1964 presidential elections. Lubell discusses the revolt of the cities, problems of the Negro, isolationism, the farm vote, and many more areas of government concern. In the 250-page book, Lubell’s perception and realism are most noticeable. **THE FUTURE** is an excellent addition to your public affairs library.

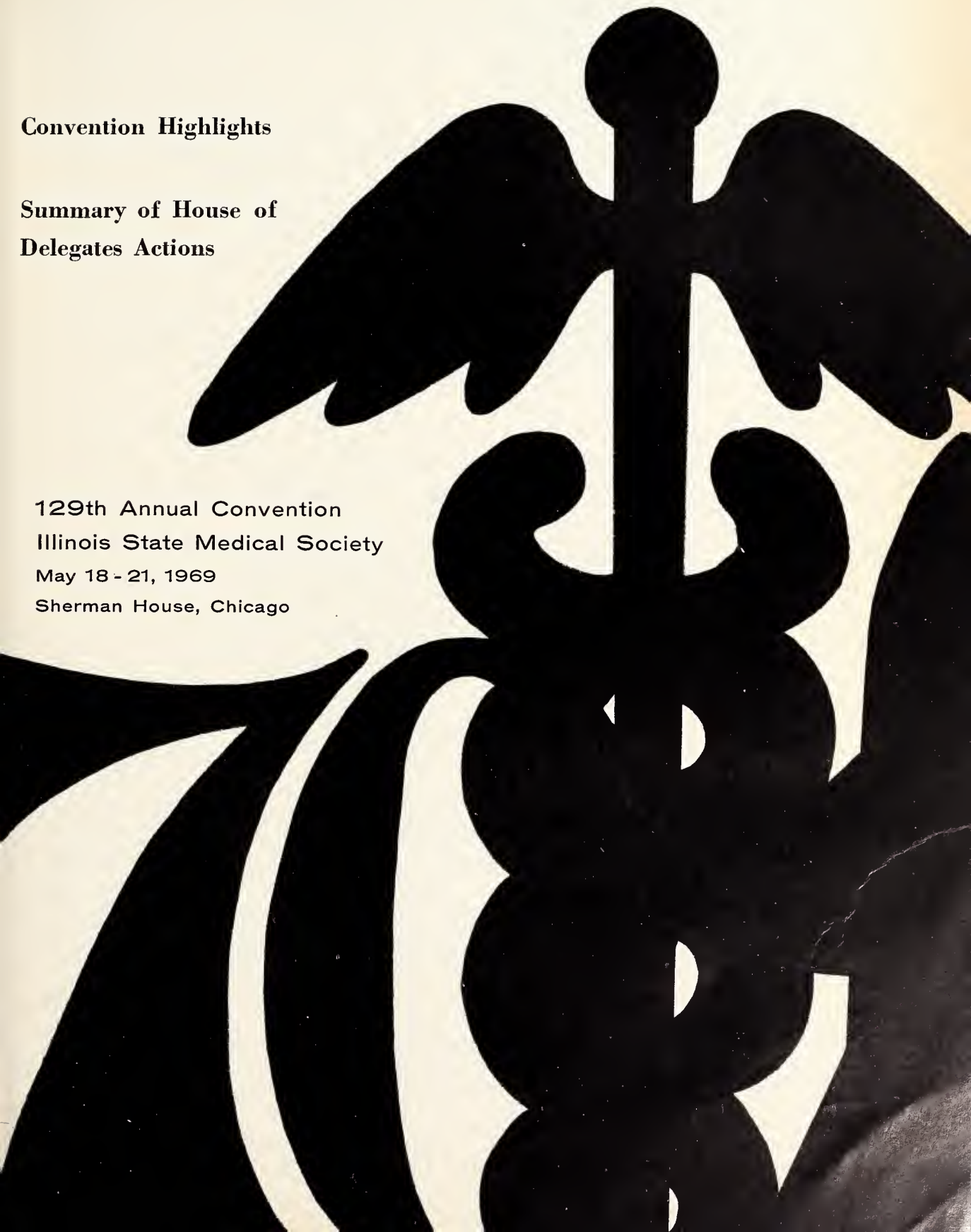
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# Medicine in the 70s

Convention Highlights

Summary of House of  
Delegates Actions

129th Annual Convention  
Illinois State Medical Society  
May 18 - 21, 1969  
Sherman House, Chicago



# 1969-1970 OFFICERS AND BOARD OF TRUSTEES

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1st Vice-President	Carl E. Clark, 225 Edward St., Sycamore 60178
2nd Vice-President	George Shropshear, 1525 E. 53rd St., Chicago 60615
Secretary-Treasurer	Jacob E. Reisch, 1129 S. 2nd St., Springfield 62704

## House of Delegates

Speaker of the House	Maurice M. Hoeltgen, 1836 West 87th St., Chicago 60620
Vice-Speaker	Paul W. Sunderland, 214 N. Sangamon St., Gibson City 60936

## Trustees

1st District	1971	Joseph L. Bordenave, 1665 South St., Geneva 60134
2nd District	1971	Wm. A. McNichols, Jr., 101 W. 1st St., Dixon 61021
3rd District	1971	Wm. M. Lees, 6518 N. Nokomis, Lincolnwood 60646
	1971	Frank J. Jirka, Jr., 1507 Keystone Ave., River Forest 60305
	1970	Wm. E. Adams, 55 E. Erie St., Chicago 60611
	1970	James B. Hartney, 410 Lake St., Oak Park 60302
	1972	Warren W. Young, 10816 Parnell Ave., Chicago 60628
	1972	Fredric D. Lake, 1041 Michigan Ave., Evanston 60202
4th District	1970	Paul P. Youngberg, 1520 Seventh St., Moline 61265
5th District	1970	Darrell H. Trumpe, St. John's Sanatorium, Springfield 62707
6th District	1972	Mather Pfeiffenberger, State & Wall Sts., Alton 62002
7th District	1970	Arthur F. Goodyear, 142 E. Prairie Ave., Decatur 62523
8th District	1970	Wm. H. Schowengardt, 301 E. University Ave., Champaign 61820
9th District	1972	Charles K. Wells, 117 N. 10th St., Mt. Vernon 62864
10th District	1972	Willard C. Scrivner, 4601 State St., E. St. Louis 62205
11th District	1971	Joseph R. O'Donnell, 444 Park, Glen Ellyn 60137

<b>Trustee-at-Large</b>	Philip G. Thomsen, 13826 Lincoln Avenue, Dolton 60419
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<b>Chairman of the Board</b>	Frank J. Jirka, Jr., 1507 Keystone Ave., River Forest 60305
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## CONVENTION HIGHLIGHTS

### ATTENDANCE TOTALS

In attendance at the 129th Annual ISMS Convention were (1968 in parentheses):

Physicians	1,684	(1,660)
Guests	332	( 304)
Auxiliary	223	( 212)
Exhibitors	350	( 350)
<b>TOTAL</b>	<b>2,589</b>	<b>(2,526)</b>

### SYMPOSIA AND SECTION ATTENDANCE INCREASED

Attendance at sections and symposia seemed increased over previous years. The wide ranging program of clinical and socio-economic programs had a broad appeal and attendance exceeded expectations.

### TECHNICAL EXHIBITORS HONORED

Presentations of plaques to 19 companies who have exhibited with ISMS for more than 20 years were made. The exhibitor with the longest tenure was Medical Protective Company, 37 years, followed by W. B. Saunders, 35 years, and Mead Johnson, 31 years. There were 57 exhibits in 1969.

**SCIENTIFIC EXHIBIT AWARDS** were given to the following:

Gold Award—Stroke: Surgical Treatment, by I. Sejdinaj, Richard C. Powers, and A. Hasan Khazei, from Sherman Hospital and St. Joseph Hospital, Elgin.

Silver Award—Freeze-Etch, Electro-Micrography, by H. Friederici, of the Department of Pathology, University of Illinois, Chicago

Bronze Awards—Conservative Therapy Stasis Ulcers, by Bert Seligman, Flower Hospital, Toledo, Ohio

Fertility After Injectable Contraception, by Merrill W. Huffman, Stanley E. Smith, Jr. and J. Roger Powell, Jr. from Carle Clinic and Carle Foundation Hospital, Urbana

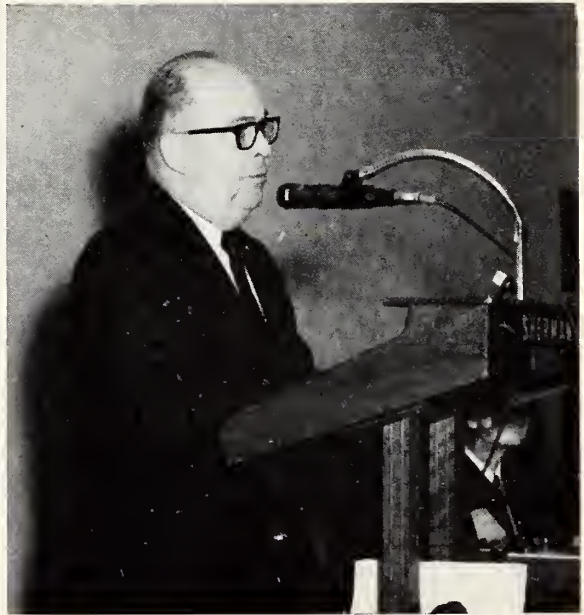
Extended Care Programs on the Community Level, by Marshall A. Falk, and Herman Weiss, of Fox River Rehabilitation Center and Louis A. Weiss Memorial Hospital, Chicago.

### ISMS PRESIDENT'S REPORT

In his presidential remarks, Philip Thomsen, M.D., reported a busy but fruitful year with many challenges. He reported successes in several approaches in medical education, such as expansion of the rapidly progressing "Preceptorship Program," increased medical school enrollments, and acceptance of all 10 recommended pre-medical students by the University of Illinois College of Medicine as a part of the ISMS sponsored Student Loan Program. He also discussed improved state-wide physician communication, and greater physician effort in socio-economic and public affairs activities. He was commended by the House for a job well done.

### PHYSICIANS GATHER TO HONOR DR. THOMSEN

Some 285 persons gathered on Tuesday evening, May 20, to pay homage to President Philip Thomsen at the Annual President's Dinner. Many congratulatory wires were read, and an entertaining program of musical events contributed to a festive affair.



**Dr. Philip Thomsen addresses the House during his Presidential report.**

### SAMA ACTIVITIES REVIEWED

The National SAMA Treasurer, Bruce Fagel, University of Illinois Medical student, reviewed SAMA activities at the local and national level, including the ISMS co-sponsored Summer Job-Education Project. Touching on the philosophy of present medicine, he stated that unless we meet the challenge of need for better medical education, we'll not meet the challenge of society for a better system of health care and its delivery. He declared that today's medical students are the agents of future changes in medicine—they must be involved with physicians today.

### CHECK PRESENTED TO MEDICAL SCHOOLS

An AMA-ERF check for \$114,032 was accepted by Acting Dean, John G. Masterson, Loyola University Stritch School of Medicine, on behalf of all five Illinois medical schools. The amount was the designated portion from the annual ISMS dues in support of medical education.

### IMAA PRESIDENT ADDRESSES HOUSE

IMAA President, Mrs. Zelma Bechtol, asked to help strengthen the Illinois Medical Assistants Association. She stressed the professional relationship of physician and assistant, education programs, being non-union, and potential monetary savings to physicians, as significant reasons for physician support of IMAA. The ISMS House took action to encourage support of IMAA chapters and asked physicians to consider underwriting membership for their assistants.

### AUXILIARY PRESIDENT GIVES REPORT

Mrs. Alden Rarick reported on a very active year. She asked physicians to encourage their wives to participate in this important society adjunct serving a definite need in the affairs of medicine and public health.



**Acting Dean of Loyola University Stritch School of Medicine, Dr. John Masterson, accepts a check on behalf of Illinois' five medical schools from President Philip Thomsen. The check, for \$114,032, was contributed as designated AMA-ERF dues from ISMS members.**

#### KANKAKEE AUXILIARY PRESENTS AMA-ERF CHECK

The Kankakee Auxiliary presented a check for \$1,042.23 to the ISMS Educational and Scientific Foundation as the proceeds from the first of a series of benefit concerts being presented throughout the state. Mrs. Eugene Dach, concert pianist, and Mrs. William T. Hodges, Kankakee Aux. AMA-ERF chairman, presented the check to Dr. Newton DuPuy, chairman of the foundation.

#### GRANVILLE A. BENNETT RECEIVES TEACHING AWARD

Dr. Granville A. Bennett received the Edwin S. Hamilton Teaching Award of the Interstate Postgraduate Medical Association of North America. The former Illinois dean received a plaque and a \$500 cash award from IPMA Trustee Mather Pfeifferberger. The annual award is presented through the ISMS Committee on Education to an outstanding educator. Dr. Bennett was dean of the University of Illinois School of Medicine from 1954 to 1967 and is now professor of pathology.

#### IMPAC REPORT

The annual report of IMPAC, presented by Dr. A. J. Faber, reflected a continuing interest on the part of Illinois' physicians in good government. In 1968 IMPAC supported 151 of the 200 persons who won seats in the Illinois Congressional Delegation and the Illinois State Legislature. The bi-partisan nature of IMPAC was reflected in the announcement that 56 of the winners were Democrats and 95 were Republicans. IMPAC continues to lead all 49 other state PACs in the amount of money contributed to AMPAC in support of Congressional Candidates. Dr. Faber called for the continued support of all Illinois physicians.

#### OREGON SENATOR ADDRESSES PUBLIC AFFAIRS DINNER

The Annual Public Affairs Dinner was highlighted by an inspirational message from U. S. Senator Robert Packwood (R.-Ore.) who defeated four term incumbent

Wayne Morse in a 1968 upset. Senator Packwood praised Illinois Medicine for its "knowledgeable political awareness and involvement."

#### FIFTY-YEAR CLUB INITIATES 61

Initiates to the ISMS Fifty-Year Club totaled 61. All of these physicians have practiced over 50 years. A luncheon in their honor was attended by some 150 persons who heard Dr. Walter C. Alvarez of the Mayo Clinic reminisce about the "good old days" of medicine. The Club, first of its kind, numbers over 500 members and was formed in 1937.

#### EDWARD W. CANNADY ASSUMES ISMS PRESIDENCY

Edward W. Cannady was inducted as president of the ISMS at the third House of Delegates session. Administering the oath of office was outgoing president Philip Thomsen. Dr. Cannady, an East St. Louis internist, has been extremely active in the cause of medicine and the public health.

President Cannady addressed the House and in his inaugural speech stressed three areas of vital concern to the medical community:

- How physicians can help curb rising medical costs,
- How the maldistribution of physicians in Illinois can be remedied,
- How doctors can best keep up with new medical knowledge in order to provide the highest quality care to their patients.

Dr. Cannady emphasized that he will attempt to address himself to the most important issues facing Illinois doctors and the entire medical profession. He asked for the support of the entire membership and called for suggestions and criticisms to aid him in his office of president. He also called for a state-wide coordinating council in post-graduate medical education.

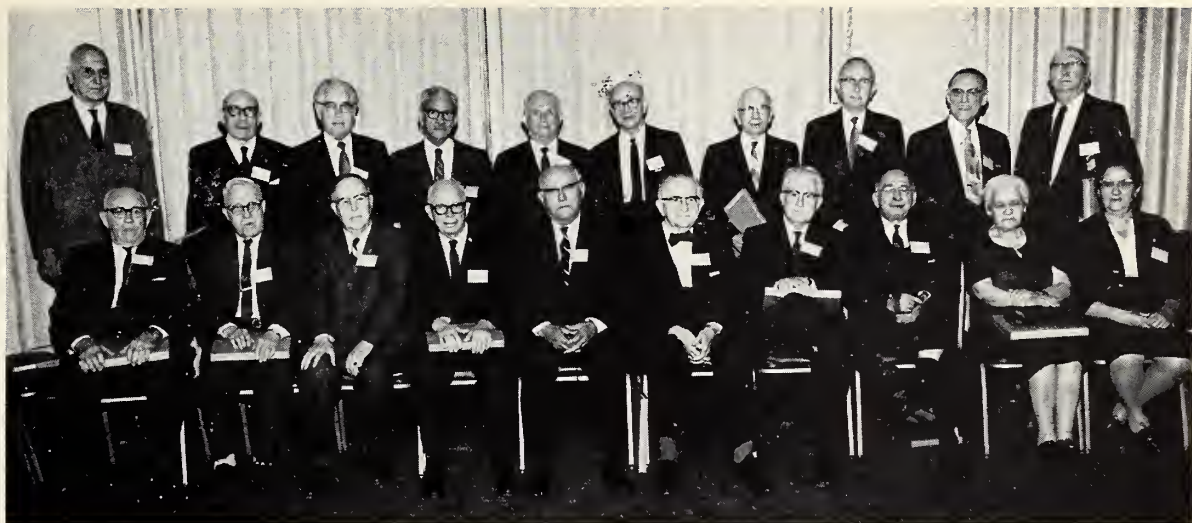
#### J. ERNEST BREED NAMED PRESIDENT-ELECT

Chicago radiologist, J. Ernest Breed, M.D., was elected ISMS President-Elect by the House of Delegates. Dr. Breed will succeed Dr. Edward W. Cannady as ISMS president in May, 1970. A physician since 1928, Dr. Breed has been active on a state-wide level in medical affairs relating to ethics, religion, legislation, cancer and radiology.



**Dr. Granville Bennett (right) former Dean, University of Illinois College of Medicine and Professor of Pathology accepts Hamilton Teaching Award from Dr. Mather Pfeifferberger, trustee of the Interstate Postgraduate Medical Education Association.**





New members of the ISMS Fifty-Year Club join for a group photograph. Some 61 members were inducted into the Club.

#### NEW OFFICERS ELECTED

The ISMS House of Delegates elected the following officers for the 1969-1970 term:

1st Vice-President	Carl E. Clark, M.D.
2nd Vice-President	George Shropshear, M.D.
Secretary-Treasurer	Jacob E. Reisch, M.D.
Speaker of the House	Maurice M. Hoeltgen, M.D.
Vice-Speaker	Paul W. Sunderland, M.D.

#### TRUSTEES

3rd District	Fredric D. Lake, M.D.
3rd District	Warren W. Young, M.D.
6th District	Mather Pfeiffenberger, M.D.
9th District	Charles K. Wells, M.D.
10th District	Willard C. Scrivner, M.D.



New president of the Illinois State Medical Society, Dr. Edward W. Cannady of East St. Louis (left) accepts the president's medallion from outgoing president Dr. Philip G. Thomsen of Dolton at the closing session of the ISMS annual meeting in Chicago. Dr. Cannady, a specialist in internal medicine, is also president of the Southern Illinois Medical Association and governor of the American College of Physicians for downstate Illinois.

#### AMA DELEGATES ELECTED

Elected members of the AMA Delegation, to begin serving a two-year term January 1, 1970, were Edward Piszczek, Theodore Grevas, Philip Thomsen, Harlan English, Edward W. Cannady, and Walter Bornemeier. Alternate delegates elected were Harold Sofield, George Turner, Francis Young, Morgan Meyer, Carl Clark, and Joseph Mallory.

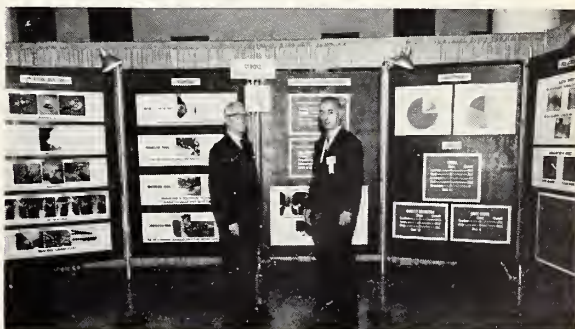
#### EXECUTIVE ADMINISTRATOR AND OFFICERS REPORT TO DELEGATES

ISMS Executive Administrator Roger N. White reported on the activities of the headquarter's staff to the House of Delegates. He discussed the financial outlook for the Society and stressed that new services within the Society are limited only by the imagination of the membership.

Maurice M. Hoeltgen, M.D., Speaker of the ISMS House reported to the House on the purposes and procedures of the various official meetings of the convention.

#### MEMORIAL SERVICE HELD

Jacob E. Reisch, M.D., ISMS Secretary-Treasurer, conducted a brief Memorial Service for recently deceased ISMS members.



Dr. Edward Cannady (left) new ISMS President, visits with Dr. I. Sejdinaj at the Gold Scientific Award exhibit by Dr. Sejdinaj.



#### DUES STRUCTURE TO REMAIN CONSTANT FOR 1970

In considering the ISMS dues structure, the House accepted the recommendation that there be no request for dues increase in the face of inflation, and such will remain at \$105.

#### DR. JIRKA RE-ELECTED CHAIRMAN

At the ISMS post-convention Board of Trustee's meeting, Dr. Frank J. Jirka, Jr., River Forest, was re-elected Chairman of the ISMS Board of Trustees. Dr. Jirka is a urologist and an ISMS Trustee for the Third District.

#### MEMBERS CHAIR REFERENCE COMMITTEES

Chairing ISMS Reference Committees at the 129th Annual ISMS Meeting were:

Constitution & Bylaws	Andrew J. Brislen, M.D.
Officers & Administration	Fred A. Tworoger, M.D.
Finances, Budgets & Publications	William Hill, M.D.
Economics & Insurance	Clarence A. Norberg, M.D.
Legislation & Public Affairs	Ralph E. Dolkart, M.D.
Scientific Services & Medical Education	Don L. Ervin, M.D.
Public Relations & Miscellaneous Business	John Holland, M.D.

#### HOUSE ACTS ON WIDE RANGE OF RESOLUTIONS

In specific actions the House of Delegates:

- Voted appropriate committee membership to SAMA members—including the right to vote in committee (but no vote out of committee) and the right to speak on the floor of the House of Delegates (with permission of the House).
- supported the principle of "peer review" in areas of ethical relations and the individual physician's right to have legal counsel present providing he does not interfere with the proceedings.



The first registrant at the 129th ISMS Annual Meeting, Dr. H. L. Fleischer, Knoxville, signs in at the registration desk. Staff member Elizabeth Lynch looks on.



Awarded a plaque for exhibiting at the ISMS annual convention for 37 years, the longest of any exhibitor, Mr. Edwin M. Breier of the Medical Protective Company, is congratulated by Dr. Robert T. Fox (left) Exhibits Director, and ISMS President Philip Thomsen (right).

- requested county medical societies to amend their constitutions and by laws so that osteopathic physicians, licensed to practice medicine and surgery in all of its branches in Illinois, may become members if they meet all other qualifications for membership at the county level.
- approved an allocation of \$10 of dues, currently part of the \$20 for AMA-ERF, to the ISMS Educational and Scientific Foundation, to coordinate promotional efforts to end the shortage of physicians, and to develop programs to furnish facilities and manpower in "health deprived" areas.
- agreed to maintain its 1966 policy to build a reserve fund equal to one year's operating expenses.
- passed a resolution to support and advance the Preceptorship Program in all Illinois Medical Schools
- approved in principle a resolution dealing with the establishment of a "non-government fiscal intermediary" to provide for administration of Medicaid (PL 89-97 Title XIX).
- agreed with the intent of a resolution which recommended that a firm set of guidelines be set up to determine the eligibility of recipients of vocational rehabilitation.
- referred a resolution specifying measures designed to improve governmental health programs to the ISMS Board of Trustees
- adopted a resolution opposing "fixed fees" and calling for a similar resolution to be presented to the AMA Meeting in New York.
- adopted a policy statement establishing alcoholism as a disease and health problem and, as such, im-

- plying that it should be treated within the purview of the medical and other health professions.
- rejected a resolution calling for the creation of a department of environmental pollution control because the problem extends beyond the realm of public health and goes into such other areas as conservation, agriculture, waterways and industry.
- re-emphasized ISMS' policy supporting the concept of "free care" for tuberculosis control.
- adopted a resolution stating that assistance in family planning should be made available to all who wish it in accordance with their individual desires and beliefs, and that such assistance should be provided only by physicians or through programs having physician support.
- rejected a resolution calling on other state and county medical societies to offer active membership to members of SAMA in their respective states.
- approved a resolution calling for ISMS to go on record in favor of free breakfasts and lunches for school children in the State of Illinois, in areas where this is necessary.
- passed a resolution supporting the labeling of prescriptions with drug, dosage and amount prescribed.
- adopted a statement calling for ISMS to instruct its legislative committee to do all within its power to resist the regulation of fees for medical services and continue the concept of usual, customary and reasonable fees.
- endorsed in principle a statement supporting a flat rate state income tax and proposing that the repeal of the personal property tax and total revision of the tax structure be considered.

- adopted a resolution requesting that the present laws regarding abortion be updated and modified to provide for termination of pregnancy in certain specific cases.
- passed a resolution calling for Society support of the State Department of Public Instruction and local boards of education in their attempt to establish programs for sound sex education.
- recommended that the Board of Trustees initiate action to increase Utilization Review Committee authority provided that legal counsel determines that physicians serving on these committees would have legal immunity.
- endorsed the concept of area-wide planning provided that this be done on a voluntary, rather than a mandatory basis.
- approved some restructuring of councils and committees in the Constitution and Bylaws to increase efficiency and elucidate duties.
- adopted a policy stipulating that laboratory directors should hold an M.D. degree, or a Ph.D. in a medically oriented laboratory science, not an M.S. as the present law requires.
- passed a resolution calling for the documentation of cases of improper medical care due to chiropractic therapy, with the understanding that this is privileged information and will be protected.
- endorsed a statement supporting the continuation of hospital oriented diploma schools of nursing and suggesting that the nursing student receiving her training from this type of institution should be awarded an associate degree of an affiliated college where this is possible.



Gathering for dinner at the Annual Past Presidents Dinner, held at the Swedish Club, were these distinguished former chief officers. From left, Leo P. A. Sweeney, Edwin S. Hamilton, ISMS Secretary-Treasurer Jacob E. Reisch, (host), Edward Piszczek, Harlan English, H. Close Hesseltine, Newton DuPuy (seated), George F. Lull, Everett P. Coleman, Arkell M. Vaughn, James H. Hutton, and Willis I. Lewis.



# SUMMARY OF ACTIONS OF THE HOUSE OF DELEGATES

## I. REFERENCE COMMITTEE ON CONSTITUTION & BYLAWS

### STUDENT MEMBERSHIP

In an effort to open new lines of communication between ISMS and medical students the House of Delegates authorized student committee membership as follows: "students nominated by Illinois Chapters of SAMA (or other recognized student organizations approved by ISMS Board of Trustees) to serve with ISMS members on appropriate committees may, by action of the Board of Trustees, be accorded committee membership for the term of the committee appointment. Such members shall be permitted full privileges of committee membership, including the right to speak on the floor of the House (with the permission of the House of Delegates), but shall have no vote out of committee. Such students shall not be eligible for the payment of travel or per diem."

Resolution 69M-27, calling for full active membership for SAMA members, and a suggestion that a membership structure similar to that of county medical societies be developed for SAMA Chapters in the Medical Schools of Illinois, were referred to the Constitution and Bylaws Committee for consideration.

Another action recommending that the Society consider the feasibility of sending the Legislative Newsletter, "Pulse," *IMJ*, Summary of Board Actions, and similar material to SAMA Chapters and members was referred to the Board of Trustees.

### LEGAL COUNSEL PRESENCE AT ETHICS HEARINGS

The House adopted changes in the use of legal counsel which will return Ethical Relations Committee hearings to the principle of *peer review*. The following statements were added to the Constitution & Bylaws:

"All parties may have legal counsel present to advise and counsel them during the proceedings; (counsel) shall be expected to be helpful to all

parties concerned, shall not be contentious, may not participate in judgement, and may be excluded from the hearing by the chairman or by vote of the committee. Proceedings shall be in the form of *peer review* in which representative physician members of the county medical society shall evaluate acts by the standards established and amended by the House of Delegates of the AMA . . . and by such additional standards as shall be incorporated in the Constitution and By-Laws of the ISMS and/or the county medical society, by local custom or tradition, and subscribed to by specific consent or implied consent through continued membership in the Society."

### ALTER COUNCIL AND COMMITTEE STRUCTURE

The names of several councils and committees were altered with corresponding changes in duties (areas of concern). The revised councils are:

- Medical-Legal Council
- Council on Legislation & Public Affairs
- Council on Education & Manpower
- Council on Economics & Governmental Health Programs
- Council on Environmental & Community Health
- Council on Public Relations & Membership Services
- Council on Mental Health & Addiction
- Council on Social & Medical Services

Section chairmen for the Annual Meeting were abolished by adoption of the following change in the by-laws:

"The scientific program shall be conceived by the Committee on Scientific Assembly and developed and implemented through the joint efforts of the Committee on Scientific Assembly and representatives of specialty groups."

## II. REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND ADMINISTRATION

The reports of Officers, Trustees, AMA Delegation, Executive Administrator, Speaker, Vice-Speaker, Auxiliary President and Advisory Committee to the Auxiliary were received with commendation for the extensive work performed. Acceptance of these reports gave endorsement to numerous suggestions for improving the Society's program and enhancement of the profession and protection of the public's welfare. No action was taken on the reports of the Committee on Committees and the Ethical Relations Committee, since direct action on these matters was called for in the report of the Constitution and By-Laws Committee.

### OSTEOPATHIC MEMBERSHIP

Recommendations of the Committee on Osteopathic Relations, and amended Resolution 69M-25, as adopted, provide membership to qualified osteopaths at the discretion of the county medical society. The RESOLVED of the resolution reads as follows:

RESOLVED, that such doctors of Osteopathy who meet all other qualifications for membership may be accepted as active members of the county medical societies throughout the state and be accorded

all courtesies of full membership at the county and state levels and so reported to the American Medical Association for acceptance at that level.

### POLICY STATEMENTS

In conformity with the AMA principles of medical ethics, a policy statement was adopted declaring that rebates of any nature to any member, county or regional medical society are unethical. The House also reaffirmed its policy in support of local health departments by adoption of the following statement:

"Public Health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts, including contributions by voluntary health associations, medical societies and other health-oriented groups.

"Full-time modern local Health Departments adequately financed and staffed at the county or multiple county level are highly desirable, and if available, would be capable of providing these services to the people throughout the state. It is of paramount importance that such departments



should be established where none now exist and that county medical societies, as well as physicians, should give their wholehearted support."

#### MEDICAL EDUCATION CAMPAIGN—PILOT PROJECTS IN HEALTH CARE

The adoption of Resolution 69M-34 authorized the Board of Trustees to utilize \$10 of the \$20 AMA-ERF 1970 dues contribution to conduct a program in support of increased medical school enrollment and to initiate pilot projects in health care delivery in deprived urban and rural areas resulting from the acute physician shortage. Elected officials and the general public will be urged to back increased state support for medical education and other measures to increase the available supply of physicians in Illinois. The pilot projects will permit in-

novations in health care delivery, including further experiments with ambulatory health care centers. The funds temporarily diverted from direct support of the medical schools, will be channeled through the ISMS Educational and Scientific Foundation, to be supplemented by additional public or private funds which may be generated for these purposes.

#### COUNTY MEDICAL SOCIETY ADMINISTRATIVE OFFICERS

Resolution 69M-5, calling for ISMS to initiate moves to establish additional administrative offices at county and/or multi-county levels throughout the state, was not adopted. The House agreed that this is a matter for individual county medical societies to decide. Consultation from the headquarters office should be made available if requested.

### III. REFERENCE COMMITTEE ON FINANCES, BUDGETS AND PUBLICATIONS

The Reference Committee on Finances, Budgets and Publications considered and accepted the following reports: Benevolence Committee, Rural Health and Student Loan Fund Committee, The Publications Committee, the *Illinois Medical Journal* Editor, and *IMJ* Editorial Board.

#### TREASURER'S REPORT

The Treasurer's Report which showed the Society's financial affairs to be in good order was accepted. The Treasurer and the Board of Trustees were commended for the following:

1. No request for a dues increase in the face of inflation.
2. Adherence to the 1965 policy of building up the permanent reserves to a figure approximately equal to one year's annual operating expenditures.

The 1970 ISMS dues allocation was set as follows:

AMA-ERF	\$10.00
Educational & Scientific Foundation	\$10.00
Benevolence Program & Reserve	\$ 5.00
Health Careers Council	\$ 2.00
Permanent Reserve Fund	\$ 8.00
General Fund	\$70.00
<b>TOTAL</b>	<b>\$105.00</b>

#### PERMANENT RESERVES

The House of Delegates, by its action in 1965, provided for an allocation of \$8 from each regular member's annual dues to be set aside for the permanent reserve fund, starting with 1966.

Although some delegates and members felt that the present permanent reserve funds (totaling approximately one-half year's operating expenses) were adequate, no change in established policy was recommended.

Resolution 69M-4, which called for the Permanent Reserve Fund to be maintained at the present level and for the dues allocation to be used for other constructive programs by the Society, was rejected. In rejecting this resolution, however, the House noted that many of the suggested programs are worthy of serious consideration by the Board of Trustees. The 1965 Reserve Fund policy will be subject to review in 1970.

#### EDUCATIONAL & SCIENTIFIC FOUNDATION

The Merck, Sharp & Dohme grant to the Foundation helped to supply speakers to many meetings in 19 counties during 1968. Society members were urged to consider the solicitation of funds for the Foundation, thus enabling other worthwhile projects to be supported. Classes of membership in the Foundation are as follows:

1. Fellows of the Foundation are physicians holding regular membership in the Foundation following the contribution of \$100 or more.
2. Associate fellows are non-physicians holding regular membership in the Foundation following a contribution of \$100 or more.
3. Honorary fellows are individuals whom the Foundation's Board of Directors elect to membership because of their exceptional service to the organization and its goals.

Dr. Newton DuPuy, chairman, and the Board of Directors were commended for their fine work.

#### PRECEPTORSHIPS

A substitute Resolution 69M-6 was adopted calling for the ISMS to support and advance in all Illinois Medical Schools the PRECEPTORSHIP PROGRAM, and that the members of the several county medical societies be given the opportunity to assist in the clinical instruction of these students.

#### BIOMEDICAL CAREERS COUNCIL

Resolution 69M-39 called for ISMS' financial support of a special summer program in bio-medical careers for Chicago inner-city students. The House of Delegates expressed approval of the objectives of this program but took no action because no method of funding was presented.

#### LAY LABORATORY ADVERTISING

Resolution 69M-8, which reaffirmed medicine's traditional opposition to the practice of medicine by lay corporations and opposition to commercial advertising of the practice of medicine, was adopted. The resolution was amended to have the Illinois AMA Delegation submit a resolution to the AMA asking for a review of policies regarding lay corporation advertising. The review should be made by the Judicial Council. No action was taken on Resolution 69M-15 which was similar in intent, but not as specific.

#### IV. REFERENCE COMMITTEE ON ECONOMICS & INSURANCE

The Reference Committee on Economics & Insurance reviewed and accepted the following reports: Council on Medical Service, Committees on Prepayment Plans, Aging, Advisory to the Illinois Department of Public Aid, Subcommittee on Drugs & Therapeutics, Usual & Customary Fees, Advisory to the Division of Vocational Rehabilitation and Report of the Director, Illinois Department of Public Aid.

##### APPROVE REPORT ON MAJOR MEDICAL INSURANCE

Due to the interest expressed during the hearing, the Reference Committee recommended that the Insurance Committee explore the possibility of extending Major Medical coverage for members beyond age 65.

##### FISCAL INTERMEDIARY FOR MEDICAID

The House of Delegates approved in principle Resolution 69M-14, proposing establishment of a NON-GOVERNMENT FISCAL INTERMEDIARY to provide administration of Medicaid (PL 89-97 Title XIX). This will effect economies in operation. The House recommended that the matter be referred to the Usual and Customary Fees Committee of ISMS.

##### EXTENSIVE IDPA REPORT REVIEWED

The report submitted by Harold O. Swank, IDPA director, was acknowledged by the committee. Much interest was engendered in committee hearings regarding usual and customary fees and fixed schedules. Since no recommendations were set forth in the report, it was received for information only.

##### USUAL & CUSTOMARY FEE STRUCTURE RE-EMPHASIZED

Resolution 69M-18, contending an alleged misapplication of the 1967 Usual and Customary Fee adjudication agreement with Blue Shield, was withdrawn. This action was taken after assurances were received from Blue Shield that referral to the County Medical Society of fee adjudication will be followed according to the agreement.

#### V. REFERENCE COMMITTEE ON SCIENTIFIC SERVICES AND MEDICAL EDUCATION

The Reference Committee on Scientific Services & Medical Education reviewed and recommended acceptance of the reports of the following: Council on Medical Education, Council on Scientific Services, Committees on Nutrition, Narcotics and Other Hazardous Substances, Rehabilitation Services, Medical Education, Continuing Education, Scientific Assembly, Advisory to SAMA, and reports of the Director, Illinois Department of Public Health and Director, Illinois Department of Mental Health.

##### CANCER COMMITTEE DISCONTINUED

The ISMS House, at the suggestion of the Reference Committee and the chairman of the Council on Scientific Services, approved the recommendation to dissolve the Cancer Committee since for the second year in a row no items of business were referred to it. The committee may be reactivated as need dictates.

##### ADOPT POLICY STATEMENT ON ALCOHOLISM

ISMS Delegates adopted a policy statement stating that

##### FEE BASIS FOR VOCATIONAL REHABILITATION CONSIDERED

The ISMS House, with regard to the Board of Vocational Education, Division of Vocational Rehabilitation, approved Resolution 69M-20 which proposed that the AMA request all state agencies of vocational rehabilitation to base the payment for services on the usual and customary fee basis.

In addition, the House endorsed the statement regarding Resolution 69M-21 which also involved the State of Illinois, Board of Vocational Rehabilitation. The committee agreed with the intent of this resolution which recommended that a firm set of guidelines be established to determine the eligibility of recipients of vocational rehabilitation.

The House also recommended that referral of recipients to the Division of Vocational Rehabilitation by physicians be encouraged.

##### IMPROVEMENT IN GOVERNMENT PROGRAMS DISCUSSED

The House of Delegates referred Resolution 69M-30, which recommended that ISMS submit specific recommendations for the improvement of government health programs to the Governor of Illinois, to the Board of Trustees. The reference committee—after much deliberation—felt that the apparent difficulty in implementing the various proposals necessitated this action. Resolution 69M-30 called for an expansion of services and improvement of facilities in medical care for the indigent. 69M-3, calling for a COMSTAT Health Care Financing structure, was withdrawn.

##### OPPOSITION TO FIXED FEES

The House accepted the recommendation that the first section of Resolution 69M-32 dealing with opposition to fixed fees be adopted. In addition, they amended the second section of the resolution to insure that this concept be transmitted to the AMA with the recommendation that it urge the government, particularly HEW, to avoid issuing any rules or regulations which would directly or indirectly fix fees.

"since alcoholism has been widely regarded as a disease for some time, and because it is impossible to differentiate immediately between a chronic alcoholic and any other intoxicated person, the individual who is acutely ill from alcohol ingestion should be considered a health problem and therefore be adjudicated within the purview of the medical and other health professions."

##### POLLUTION CONTROL BOARD

The ISMS House did not adopt the policy statement set forth by the Committee on Public Health. The statement called for controls within the Department of Public Health. Environmental pollution control extends beyond the realm of Public Health and into such other areas as conservation, agriculture, waterways and industry. Thus, the House called for the creation of a State Pollution Control Board separate from the Department of Public Health.

##### FREE CARE FOR TB CONTROL SUPPORTED

The House, in its consideration of the concept of



"ability to pay" for TB care, supported the concept of "Free Care" for tuberculosis control.

#### **STRENGTHEN COMMUNICATION REGARDING RADIATION**

The House adopted the Radiation Committee's policy statement requesting the Illinois Department of Public Health to appoint to its various advisory committees such ISMS committee chairmen or delegates as will be appropriate for maintaining adequate communication between the department and the Society, thus enhancing the opportunity to provide the leadership of the Society with up-to-date information while there is ample time for action.

#### **HOUSE SUPPORTS MANDATORY HEALTH EDUCATION**

The House adopted the supplementary report of the Committee on Child Health which proposed that a joint committee of educators and medical personnel sponsor and actively participate in encouraging legislation for Mandatory Health Education in Illinois schools.

#### **COURSE ON PATIENT CARE COSTS SUPPORTED**

The ISMS delegates adopted Resolution 69M-7 calling for a course on patient care costs being included as a required part of the curriculum of the medical schools in the State of Illinois and requesting that the Illinois AMA Delegation introduce a similar resolution to the AMA House of Delegates in July in New York.

#### **PRECEPTORSHIP PROGRAM BROADENED**

The House adopted Resolution 69M-10 which suggested that county medical societies make direct contact with medical schools in Illinois to initiate Preceptorship Programs similar to the one presently being sponsored by DuPage County and the Chicago Medical School.

### **VI. REFERENCE COMMITTEE ON LEGISLATION AND PUBLIC AFFAIRS**

The Reference Committee on Legislation and Public Affairs reviewed and accepted the following reports: Council on Legislation, Medical-Legal Council, Committees on Public Affairs, Eye Health, Impartial Medical Testimony, Medical Practice & Quackery, Laboratory Evaluation, and Comprehensive Health Planning.

#### **LABELING OF PRESCRIPTIONS SUPPORTED**

The House adopted Resolution 69M-19 which called for the labeling of prescription drugs with drug, dosage and amount prescribed.

#### **FEE REGULATIONS RESISTED**

Resolution 69M-22, calling for ISMS to instruct its legislative committee to do all within its power to resist the regulation of fees for medical services and continue the concept of usual, customary and reasonable fees, was adopted.

#### **ISMS TO COMPILE STATISTICS ON IMPROPER MEDICAL CARE**

ISMS Delegates adopted Resolution 69M-31 calling for the Council on Legislation and Public Affairs to gather, maintain and verify a list of improper medical care administered by chiropractors for use by the legislative office of the Society. This material will be considered privileged information and be made available only to authorized medical personnel.

#### **VOLUNTARY FAMILY PLANNING INFORMATION SUPPORTED**

The House adopted Resolution 69M-11 which stated that assistance in family planning should be made available to all who wish it in accordance with their individual beliefs and desires, and that such assistance should be provided only by physicians or through programs conducted with support of physicians, and should always preserve the individual's acceptance of the methods used.

#### **MEDICAL STUDENT LOAN PROGRAMS BACKED**

Resolution 69M-26 which called on all county medical societies to establish scholarship and long-term low-interest loan programs for medical students who live in that county was adopted.

#### **MEMBERSHIP FOR SAMA MEMBERS**

The House rejected Resolution 69M-28 which called for ISMS to encourage all state and county medical societies to offer full active membership to members of SAMA in their respective states.

#### **SUPPORT OF HEALTH PROFESSIONS LOAN PROGRAM**

The Delegates adopted Resolution 69M-29 which supported the Health Professions Loan Program and called on ISMS officers to send letters to all Illinois Congressmen expressing a desire to see these funds provided in the original amount requested.

#### **FREE MEALS FOR SCHOOL CHILDREN SUPPORTED**

The House adopted Resolution 69M-35 calling for ISMS to go on record in favor of free breakfasts and lunches for school children in the State of Illinois, in areas where this is necessary. The House did not adopt, however, the portion of the resolution stating that no family's food allowance be less than the Lowest Standard Allowance of the Bureau of Labor Statistics, and that food depots be set up around the state to feed the hungry.

#### **ADOPT REPORT CALLING FOR ESTABLISHMENT OF MALPRACTICE SCREENING PANEL**

Establishment of a malpractice screening panel in Illinois described in the report of the Medical-Legal Council was approved. After extensive discussions with ISMS legal counsel, a plan will be proposed to the Chicago and Illinois Bar Associations whereby: 1) a panel would be set up consisting of two lawyers, two physicians, and a judge, 2) either before or following the filing of suit the parties would present their case to the panel, 3) if the panel concludes that there is merit in the claim, it recommends a settlement. If the panel finds that there is no merit, it recommends that the suit be dismissed. Under the plan, expert testimony must be provided in cases involving meritorious claims. Where claims lack substance the plaintiff's lawyer must withdraw, as previously agreed, prior to submitting the case to the panel.

#### **MODIFICATION OF RECIPROCITY REQUIREMENTS REJECTED**

The House rejected Resolution 69M-24 calling on ISMS to prepare legislative bills and the necessary regulatory procedures to change the reciprocity requirements as they now exist in Illinois.

#### **ORAL PHYSICIAN EXAMINATION REQUIREMENTS UPHELD**

The ISMS Delegates defeated Resolution 69M-38, which, since there is such an acute shortage of physicians in



Illinois, called for elimination of a clinical examination as a condition of medical licensure in the State of Illinois on the basis of reciprocity or endorsement of the certificate of the National Board of Medical Examiners.

Resolution 69M-37 was rejected by the House of Delegates. Similar to Resolution 69M-24, this resolution also sought to change the existing laws requiring reciprocity procedures.

#### **FLAT RATE STATE INCOME TAX ENDORSED**

The House of Delegates adopted Resolution 69M-33 which endorsed and supported in principle a flat rate state income tax, with equitable allowances for personal exemptions. They also adopted a statement proposing that the repeal of the Personal Property Tax and total revision of the tax structure be considered and that the Governor of Illinois and all members of the Illinois Legislature be sent a copy of this resolution.

#### **ABORTION RESOLUTION ADOPTED**

The House rejected Resolution 69M-16 which called for

ISMS to assume no stand on the liberalization of existing laws regarding abortion in Illinois. Instead, the House adopted Resolution 69M-13, introduced by the Maternal Welfare Committee, which requested that the present laws be updated and modified to provide for cases where:

1. There exists documentation of a severe threat to the health or life of the mother, or
2. There is documented medical evidence that the conceptus may be born with incapacitating physical or mental abnormality, or
3. There is documented evidence that continuation of a pregnancy resulting from statutory or forcible rape or incest may constitute a threat to the mental or physical health of the patient, and
4. Two other physicians chosen because of their recognized professional competence have examined the patient and concurred in writing, and
5. The procedure is performed in a hospital legally licensed and approved by the State of Illinois for the care of maternity patients.

### **VII. REFERENCE COMMITTEE ON PUBLIC RELATIONS AND MISCELLANEOUS BUSINESS**

The Reference Committee on Public Relations and Miscellaneous Business reviewed and accepted reports of the following: Council on Public Relations, Committees on Public Relations, Religion and Medicine, Public Safety, Disaster Medical Care, Membership, Advisory to Paramedical Groups, Advisory to Interprofessional Groups and Hospital Relations.

#### **SOUND SEX EDUCATION SUPPORTED**

Resolution 69M-23 was amended and subsequently adopted by the ISMS delegates. The resolution called for the Society to support the State Department of Public Instruction and local boards of education in their efforts to encourage appropriate family life and sex education programs where desired by the parents of the students involved. The resolution also pledged ISMS' assistance in providing appropriate educational and promotional materials necessary to assure high quality programs of family life and sex education throughout the state.

#### **SUPPORT DISASTER MEDICAL CARE RESOLUTION**

The ISMS House approved Resolution 69M-1 introduced by the Committee on Disaster Medical Care and calling upon ISMS to strongly support the Packaged Disaster Hospital and the Natural Disaster Hospital programs in all Illinois Hospitals. The resolution also called upon ISMS to urge the Illinois Hospital Association and Medical staffs of its component member hospitals to cooperate in personnel training for such programs and in the storage of PDH or NDH units, and that ISMS urge support by hospital medical staffs for the Hospital Reserve Disaster Inventory Program.

#### **DIPLOMA NURSING SCHOOL PROGRAMS SUPPORTED**

The House amended and adopted Resolution 69M-9 resolving that ISMS resist efforts to transfer the major functions of the hospital oriented diploma school to the junior college, and the university. The measure further calls upon ISMS to urge that public funds be provided to the students of the hospital nursing schools, as is granted to students in other fields; and that the nursing students of the hospital diploma school be granted the Associate Degree of an affiliated college where this is possible.

#### **IMAA ACTIVITIES SUPPORTED**

The ISMS House approved Resolution 69M-17 calling for ISMS to encourage county medical societies to provide leadership in the formation of IMAA chapters in their counties, to encourage physicians to underwrite the medical assistants' membership dues in IMAA, and to encourage county medical societies to invite the IMAA county chapter presidents to their meetings.

#### **AREA-WIDE PLANNING ENDORSED**

The concept of "area-wide planning" was endorsed by the Reference Committee provided that this be done on a voluntary, rather than a mandatory basis.

#### **MEMBERSHIP BROCHURE PRAISED**

The committee was impressed with the new promotional brochure of the Membership Committee and urged the Board of Trustees to make available the necessary funds for its widest distribution and reprinting.

#### **PLACEMENT SERVICE COMMENDED**

The constantly expanding efforts of the Physicians Placement Service which attempts to bring physicians to communities in need of medical services was noted. The Committee emphasized that this has been a most difficult task in light of the manpower shortage.

#### **PR COMMITTEE EMPHASIS SHIFT**

The Reference Committee noted with interest the Public Relations Committee's shift in emphasis from health education to membership and socio-economics.

#### **COMMEND MEDICINE AND RELIGION COMMITTEE**

The Medicine and Religion Committee was commended for its pioneering efforts in the creation of its awards and seminary programs, and the publication of the booklet entitled, "What Every Physician Should Know About the Religious Needs of His Patient."

#### **UR COMMITTEE'S AUTHORITY INCREASED**

An increase in the Utilization Review Committee's authority to eliminate unnecessary hospitalization was endorsed by the House, provided that the legal immunity of physicians serving on UR Committees is assured.

## ACTIONS ON RESOLUTIONS

### 1969 HOUSE OF DELEGATES

<u>Number</u>	<u>Introduced by</u>	<u>Title</u>	<u>Action</u>
69M-1	H. C. Lueth for Disaster Med. Care Committee	Package Disaster Hospitals	Adopted
69M-2	CMS	ISMS membership for Osteopaths	For Information No action
69M-3	CMS	Health Care Financing	Withdrawn
69M-4	Will-Grundy	Use of Reserve Funds	No action
69M-5	Will-Grundy	Establishment of county offices of administration	Not adopted
69M-6	Will-Grundy	Establishment of further precep- torship programs	Substitute Resolution adopted
69M-7	DuPage County	Medical Schools to teach course on Patient Care Costs	Adopted
69M-8	Macon County (considered w/#15)	Advertising of medical specialty by lay corporations	Adopted
69M-9	Fulton County	Support for all forms of nursing education	Substitute reso- lution adopted
69M-10	DuPage County	Chicago Medical School—DuPage Co. Preceptorship Program	Adopted
69M-11	R. R. Hartman for Maternal Welfare Committee	Support for Dept. of Public Health policy statement re: Family Planning	Adopted
69M-12	CMS	Additional representation in House and on Board of Trustees	Withdrawn
69M-13	R. R. Hartman for Maternal Wel- fare Committee	Policy statement relative to Therapeutic Abortion	Adopted
69M-14	Macon County	Establishment of non-government fiscal agent for PL 89-97 Title XIX	Referred to U. & C. Fees Committee
69M-15	James B. Hartney (considered w/#8)	Solicitation & commercial advertising of medical specialty by lay cor- porations in AMA publications	No action
69M-16	A. E. Joslyn	Policy statement relative to abortion	Not adopted
69M-17	Philip Thomsen	Leadership & encouragement Ill. Medical Asst's. Association	Adopted
69M-18	Kane County	Abuse of agreement re: Usual and Customary Fees	Not adopted
69M-19	Madison Co.	Labeling of prescriptions w/drug, dosage and amount prescribed	Adopted
69M-20	Will-Grundy	Vocational Rehabilitation fee schedule	Adopted

<u>Number</u>	<u>Introduced by</u>	<u>Title</u>	<u>Action</u>
69M-21	Will-Grundy	Vocational Rehabilitation assistance	Adopted as amended
69M-22	St. Clair Co.	Fixing of medical fees	Substitute resolution adopted
69M-23	Winnebago Co.	Support for sound sex education	Substitute resolution adopted
69M-24	Vermilion Co. (considered w/ #37 & #38)	Modification of reciprocity requirements	Not adopted
69M-25	Wm. E. Adams for Osteo. Com.	Membership in ISMS for Osteopaths	Adopted as amended
69M-26	Herschel Browns	County Loan and Scholarship Program	Adopted
69M-27	J. Ingalls for Council on Med. Education	Medical Student Membership	Ref. to C. & Bylaws Com.
69M-28	J. Ingalls for Council on Med. Education	Relationship-state and county medical societies and SAMA	Not adopted
69M-29	Morgan Meyer Council on Med. Education	Health Professions Loan Programs	Adopted
69M-30	Clark County	Governmental Health Programs	Ref. to Board of Trustees
69M-31	Crawford Co.	Compilation of Chiropractic Statistics	Adopted
69M-32	Henry-Stark Co.	Opposition to Fixed Fees	Substitute resolution adopted
69M-33	F. Jirka, Jr. for Bd. of Trustees	State Income Tax	Adopted as amended
69M-34	F. Jirka, Jr. for Bd. of Trustees	Funds for Medical Education and projects in Health Care	Adopted
69M-35	A. S. Klinger	Food allowances and School lunches for Illinois	Adopted as amended
69M-36	Trustees ISMS	Relocation of Headquarters offices	Withdrawn
69M-37	Vermilion Co. (considered w/ #24)	Amendment to State Medical Practice Act	Not adopted
69M-38	Rock Island Co. (considered w/ #24)	Change of Oral physician examination requirements	Not adopted
69M-39	So. Side Branch CMS & Cook Co. Physicians' Assn.	Support for Biomedical Careers Council	No action





# Membership Forum

## As Others See Us

*The story below appeared as an editorial in the Quincy "Herald-Whig," Sunday, May 25. In light of the many stories condemning certain facets of medicine, particularly government programs, this refreshing bit is most appreciated.*

During its annual meeting in Chicago last week the Illinois State Medical Society spoke out firmly upon a number of controversial issues. There was a time—and not too many years ago—when that same society in common with most other state medical groups, would not have touched some of the issues with a 10-foot pole. It is a refreshing view of members of a profession not normally given to ideas that might be construed as liberal.

True, the decisions reached were not necessarily those of the entire 10,900 (sic) membership. But they were the considered decisions of the society's governing body, the House of Delegates, representing the entire body and chosen by democratic vote.

The policy-making group took no stand on the subject, but the society heard a Yale faculty member discuss the need in the near future for "assistant physicians," something the profession would not have heard with any sympathy even a few short years ago. And the House of Delegates adopted resolutions which are, in the light of past experience, almost radical. For example, they included resolutions which:

Support a liberalized state abortion law.

Endorse school sex education programs with parental consent.

Favor a flat rate state income tax.

Support a program of free school breakfasts and lunches in areas where they are needed.

It wasn't quite that simple, of course. The society has always been basically conventional and conservative. On the abortion resolution, for example, there was a reported 45 minutes of debate, and the House of Delegates' final resolution opposed induced abortion except under certain conditions. The conditions are:

1. When there is documentation of severe threat to the health or life of the mother.

2. When there is documented medical evi-

June 5, 1969

Dear Dr. Van Dellen,

The Department of Psychiatry, College of Medicine, University of Iowa, Iowa City, announces the availability of psychiatric residencies for physicians who have been in practice at least four years and are not over 45 years of age. Stipends are \$12,000 per year for three years and are supported by the Public Health Service. For information write Paul E. Huston, M.D., Head, Department of Psychiatry.

Very sincerely yours,

Paul E. Huston, M.D., Head  
Department of Psychiatry

*Ed. note: Membership Forum is a means for the ISMS physician to express opinion and viewpoint on varied topics. If you have an item you would like brought before your fellow practitioners, please submit it to Membership Forum, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601. Communications should not exceed 250 words. The right to abstract or edit is reserved. Names will be withheld upon request, but anonymous letters will not be accepted.*

dence that the conceptus may be born with an incapacitating physical or mental abnormality.

3. When there is evidence that continuation of a pregnancy resulting from statutory or forcible rape or incest may constitute a threat to the patient's mental or physical health.

4. That two other physicians concur in writing following examination of the patient and that the procedure be performed in a licensed hospital with maternity care services.

Some may say the resolution favoring sex education was watered down considerably, but it was more than might have been expected in view of present organized opposition to such courses. It resolved to support "the state department of public instruction and local boards of education to encourage appropriate family life and sex education programs where desired by the parents of students involved." That last admittedly is a sop to some current views, but is sane.

It was encouraging, too, that the House of  
(Continued on page 110)

## *Looking for a Place to Practice?*

### *Placement Service Lists Openings*

In an effort to reduce the number of towns in Illinois needing practicing physicians, the *Journal* is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

**MORGAN COUNTY:** Franklin; population: 500. Trade area: 2,000. Nearest physicians at Waverly, 6 miles, and Jacksonville, 13 miles. Two hospitals. Located 35 miles from Springfield. Lions Club anxious to help a physician locate here. Club has made arrangements for office and residential space. Financial assistance, if desired. Agricultural community. Grade and high schools. Two nearby lakes. For further information contact: Mr. Leroy Sweet, Franklin; Mr. Ralph Dahman, Franklin; or Dr. Charles W. Johnson, Waverly.

**OGLE COUNTY:** Chana; population: 300. Trade area: 2,500. Last physician died in 1959 after practicing 43 years. Nearest physicians and hospitals at Oregon, 7 miles. 30 miles from Rockford, population 105,000. CB&Q railroad. Combined office and home of deceased physician for sale if desired. Agricultural community. Churches: Methodist, Lutheran, Congregational and Christian. Nearest Catholic church at Oregon. Local grade school; high school at Oregon. Nearest recreational facilities: 7 miles. For further information contact: Mrs. Robert S. Johnston, Chana. Phone: Oregon 2-6338.

**OGLE COUNTY:** Mt. Morris; population: 3,500. Trade area: 7,500. Four physicians until recently; one left: age 64. Nearest hospital at Dixon, 17 miles. Two drug stores. Fi-

nancial assistance available. Senior citizens home with 120 beds. Printing company employs 1,300. Five Protestant churches. Grade and high schools. Recreational facilities: golf, swimming pool, state and local parks, good fishing and hunting. For details contact: George Aderton, Box 151, Mt. Morris; phone: 734-4116.

**OGLE COUNTY:** Rochelle; population: 8,200. Growing rapidly. Urgent need for additional G.P.s. Office facilities available; 5 physicians in town. New addition to hospital, 73 beds. Housing available. Several well known industries. Protestant and Catholic churches. Public and parochial schools. Excellent 18 hole golf course within city limits. Beautiful country club and pool; new Vagabond Health Club. Rockford, 25 miles; 75 miles from Chicago. For detailed information contact: William F. Hayes, 411 Lincoln Highway, Rochelle; phone: 562-2159.

**OGLE COUNTY:** Stillman Valley; population: 750. Trade area: 1,500. Town without a physician for several years. Nearest Dr. at Byron, 5 miles; Rockford 15 miles. Community willing to raise fund for physician's office building. Predominant nationality: Swedish and German. Agricultural community. Many residents employed in Rockford factories. Congregational and United Christian churches. Grade and high schools. \$8,000,000 bank has built new bldg. Population gain of 40% from 1950 to 1960. For details contact Mr. Joe A. Shewman, Mr. Eno Wiltfang, or Mr. Wm. Eickman, Stillman Valley.

**PEORIA COUNTY:** Princeville; population: 1,300. One physician: need for a second due to deaths of other two. Nearest hospitals at Peoria, 25 miles. Plans for new hospital at nearby Chillicothe. Local drug store. Newly remodeled office available with 6 months' free rent. Agricultural area; 3 factories and 3 rock quarries. Potestant and Catholic churches. New high school. Nearest country club with golf course, 8 miles. Below average real estate taxes. For details contact Mr. Wm. German, President, Chamber of Commerce, Princeville. Phone: 385-4757.



# Was She There? Doctor

BY SANDRA BREDTHAUER

Did your Medical Assistant attend the Illinois Medical Assistants Association annual meeting at Stouffers Oak Brook Inn on Friday, Saturday and Sunday, April 18, 19, and 20, 1969? If she did not, she missed a very interesting, educational meeting.

The theme of the educational program was directed toward better communications. This included a panel discussion of the means of "Communicating Our Concern." The Awards Luncheon Speaker was Dr. Jack Schreiber, Canfield, Ohio, renowned speaker who has won two Freedom Foundation Awards. Dr. Schreiber spoke on the principles of freedom and patriotism.

One of the highlights of the Friday meeting of the House of Delegates, the governing body of this Association, was the election of five physicians to serve as an Advisory Committee to this 500-member organization. Elected were Dr. Thomas R. Harwood, Chairman, Highland Park; Dr. Anna E. Barnstable, Waukegan; Dr. Allison

Burdick, Sr., Chicago; Dr. Lloyd F. Walk, Belleville; and Dr. John L. Wright, Bloomington. Dr. Carl Clark of Sycamore has been appointed by the Illinois State Medical Society as liaison to this Committee.

Officers serving for the coming year are President, Mrs. Zelma Bechtol, Lake Villa; President-Elect, Miss Ina Yenerich, Elgin; First Vice-President, Mrs. Vivian Johnson, Chicago; Second Vice-President, Mrs. Mary Siers, Belleville; Recording Secretary, Miss Phyllis Bredthauer, Elgin; Corresponding Secretary, Mrs. Marian Jenkins, Highland Park; Treasurer, Mrs. June Hall, Danville; Speaker of the House, Mrs. Synobia Payne, Chicago.

If your Medical Assistant is interested in membership in this organization, please contact either Mrs. Vivian Johnson, First Vice-President, 9105 S. Albany, Evergreen Park, Illinois 60642 or Mrs. Mary Siers, Second Vice-President, 801 North 84th Street, East St. Louis, Illinois 62203.

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## RECORD KEEPING

The doctor has been reminded of the importance of keeping records of his care of every patient; however, he must also bear in mind the importance of keeping those records factual. Careless or needless remarks in the records, as well as careless or heedless remarks made in conversations with or about the patient may, at some later date, be used to jeopardize the successful defense of an otherwise defensible lawsuit. The outcome of a lawsuit may often be determined merely on the credibility of the witness's testimony; if the chief witness can be discredited, it may well be enough to tip the scales in the opponent's favor. (**The Doctor and The Law**, No. 2, [1969] Law Department of The Medical Protective Company, Fort Wayne, Ind.)



# THE RESPONS GAF



# practice management *NEWS*

*A Service of the Public Relations and Economics Division*

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## Questions From Our Readers

"I have just become a staff member of a prominent local hospital that is planning to wage a major building program. All of us are expected to contribute, but being in practice only three months, I'm not in a position to do so. Am I obligated to contribute?" Dr. J.M.

According to the AMA Judicial Council's "Opinions and Reports," compulsory contributions from medical staff members are unethical. Neither the hospital management nor medical staff can base your staff appointment on your willingness to give to these causes. They cannot threaten you with expulsion if you don't wish to contribute.

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"Our hospital is finding it difficult to staff the emergency room adequately. Is there something that we—the medical staff—can do to alleviate this problem?" Dr. G.V.

The AMA suggests that the hospital staff can form itself into a "medical partnership" that employs a physician to take care of emergency cases along with other duties in the hospital. This physician would be paid by the staff rather than the hospital.

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"I have just perfected a new surgical instrument which a local manufacturer is interested in producing. Since I'm still in practice, am I allowed to patent and sell it?" Dr. C.V.

Sure, there's nothing unethical about patenting and selling your discovery. But don't restrict the sale or use of the instrument. Make it available to everyone in the medical profession to use in research or any other way that will benefit the public.

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"One of our partners died recently. May we retain his name on the office door and stationery out of respect to his memory?" Dr. K.L.

Generally, your county medical society determines if this practice is misleading or offensive to local custom. Using a deceased physician's name is not in itself a violation of the Principles of Medical Ethics. But some indication that he is deceased—such as "John Brown, M.D., 1900-1967"—is suggested. The Council agrees that continued use of the name is a "fitting tribute to the memory of one who contributed materially to the advancement of medicine."



# SOCIO ECONOMIC *news*

*A service of the Public Relations and Economics Division*

BY JOSEPH J. LOTHARIUS

## **Medicaid Costs Up 300% in Four Years**

Costs for providing medical care to welfare and medically indigent patients in Illinois have increased nearly 300% in the last four years . . . since the advent of medicaid. These soaring costs triggered a series of investigations by the *Chicago Tribune* "involving possible fraud and unethical practices." In June, *The Tribune* stated its investigation "has revealed that welfare medicine has become an extremely lucrative business with a handful of doctors, dentists, optometrists and drug stores collecting millions of dollars a year in public aid money."

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## **ISMS Position On IDPA Payments To Salaried Hospital M.D.s**

The ISMS Board of Trustees approved a recommendation from the Medical Advisory Committee to IDPA that: "Full-time and part-time salaried hospital physicians employed in a tax-supported government institution may be reimbursed by IDPA for professional services rendered to IDPA recipients, *provided such services are performed outside the tax-supported government institution.*"

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## **O.K. IDPA Payments to Non-Salaried M.D.s**

ISMS board members also approved IDPA payments to *non-salaried attending physicians* of IDPA recipients in tax supported government hospitals—on an individual basis—for professional services rendered to IDPA recipients.

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## **If Hospital Bills IDPA For Services, Doctors Can't**

If a non-tax supported hospital does not include the physicians' salaries in its billings to IDPA, the ISMS Board says full-time and part-time salaried physicians may be reimbursed by IDPA for professional services rendered to IDPA recipients who are their private patients. If the physicians' salaries are included in the hospital billings to IDPA, the physicians *should not* be reimbursed by IDPA.

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## **Board Recommends 1. M.D. Evaluation 2. Pilot Health Centers Be Set Up**

The Board of Trustees also recommends that IDPA adopt a policy to evaluate the practices of all physicians receiving more than \$25,000 last year in public aid payments. It was emphasized that *such evaluation would not be an indictment of the listed physicians, but an evaluation of the quality of care rendered by these physicians.* It also suggests that ISMS, in conjunction with county medical societies, undertake pilot studies in the development of outpatient health centers in the state where they are needed.



## Emergency Room Pamphlets Available

Two new pamphlets intended to educate physicians and patients on emergency room use are being distributed by ISMS. Designed to alleviate abuses of emergency rooms by needless utilization, these brochures should help keep the lid on rising health costs in at least one area. ISMS suggests the brochures be distributed in physicians' waiting rooms, hospital lobbies, emergency rooms, in doctors' lounges, and other appropriate high traffic centers. Brochures are available without charge by writing to the ISMS Public Relations Division, 360 N. Michigan, Chicago, 60601.

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## ISMS Opens Doors to Osteopaths

A resolution to admit osteopaths to ISMS membership was approved by the House of Delegates. The final resolve stated that "such Doctors of Osteopathy who meet all other qualifications for membership may be accepted as active members of the county medical societies throughout the state and be accorded all courtesies of full membership at the county and state levels and so reported to the American Medical Association for acceptance at that level."

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## ISMS Speaks Out on Controversial Issues

The ISMS House of Delegates approved policy stands on several controversial issues. They adopted resolutions: supporting a liberalized state abortion law; endorsing school sex education programs with parental consent; favoring a flat rate state income tax; and supporting a program of free school breakfasts and lunches in areas where they are needed.

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## Dr. Wright Adams Resigns From IRMP

The Illinois Regional Medical Program's executive director, Dr. Wright Adams, resigned his position July 1. IRMP, spawned by Public Law 89-239 (the "Cancer-Heart-Stroke" statute), also cut its official ties with the state government when it abolished requirements that the Governor appoint membership of its statewide Advisory Committee.

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## Majority of MD's Favor Assignment Billing

How many Downstate physicians accept assignments under Medicare? A great percentage of them, according to the Continental Casualty Company, Downstate carrier for Medicare Part B. As proof, Continental reports that—of the \$20 million it paid in Medicare claims last year—\$14 million went to physicians accepting assignments.

## YOUR ISMS INSURANCE QUESTIONS

**QUESTION:** If I incorporate my practice what happens to my Keogh funds?

**ANSWER:** The Keogh law provides that if a beneficiary withdraws funds before age 59½, unless he is disabled, the money is subject to penalty taxes.

Recently, a Keogh participant was penalized when he cashed in his existing contract to put the proceeds into a new qualified pension plan.

To avoid such penalty, Keogh participants who have incorporated, have directed the trustees of their Keogh plan to give the money directly to the new plan's custodian. Others have avoided this penalty by signing pacts to pay the money to their new pension trust.

In conclusion, the best advice is to work with your legal or tax counsel so as to avoid any possible question of premature distribution.

*Do you have a question of general interest on any ISMS-sponsored insurance program: Retirement Investment, Keogh, Group Disability, Group Major Medical, Professional Liability (Malpractice)? Send it to this column: "Your ISMS Insurance Questions," Illinois Medical Journal, 360 N. Michigan Avenue, Chicago, Ill. 60601. The column is a service of the ISMS Committee on Medical Economics and Insurance.*

### Ominous Threat to Business Success

"The free enterprise system cannot continue to succeed if private business is not willing to play a role in shaping our environment as well as responding to it. We cannot afford to bear the cost of decadent cities or urban chaos or civil disorders. . . . Most important in long-range corporate planning is to put the urban problem on the organization chart."—G. William Miller, president, Textron, Inc.

## Medicine and Religion Booklet Available

The Committee on Medicine and Religion of the ISMS has developed a booklet entitled "What Every Doctor Should Know . . . about the religious needs of his patients." This attractive informative booklet will be distributed to all hospital nurs-

ing stations in Illinois and to all chaplains' offices. For your copy and for additional copies for your clergyman fill in and return the coupon below. Limited supplies are available.

### MEDICINE-RELIGION BOOKLET ORDER FORM

Please send me ..... copy(ies) of booklet, "What Every Physician Should Know About the Religious Needs of His Patients" at 15c per copy. Enclosed is cash, check or money order for \$..... .

Name....., M.D.

Address.....  
(number) (street) (city) (zip)

Please detach and return to:  
Committee on Religion and Medicine  
Illinois State Medical Society  
360 North Michigan Avenue  
Chicago, Illinois 60601

tion of the quality of care rendered. The results of this study will be reported back to the Advisory Committee to IDPA.

Also upon recommendation of the Advisory Committee, the Board voted that ISMS undertake pilot studies in the development of outpatient health centers in those areas of the state where they are needed. These projects to be in conjunction with the county medical societies concerned.

## MALPRACTICE SCREENING PANEL

Dr. Noel Shaw reported that the Medical-Legal Council of ISMS was pleased to announce completion of negotiations with a subcommittee of the Chicago Bar Association regarding establishment of a "medical professional liability screening panel." He pointed out to the Board that the Illinois plan will follow the New Jersey plan closely, except that the Illinois screening panel will be mandatory before any trial litigation could ensue. Upon approval of the House of Delegates of ISMS, the plan would then be presented to the Board of Governors of the Illinois State Bar Association at their annual meeting in June. If both groups approve the measure, the Court Administrator and the Supreme Court would be requested to implement the plan by means of adoption of a Supreme Court rule. Dr. Shaw further indicated that the committee felt that the establishment of this screening panel would result in litigation of fewer nuisance suits and would result in lower settlement of cases in which there is liability.

## IDPA REIMBURSEMENT FOR SERVICES RENDERED

By official action the Board, upon recommendation of the Advisory Committee to IDPA, approved the following payment procedures for full- and part-time salaried hospital physicians employed in a tax-supported government institution.

1. Full time and part time salaried hospital physicians employed in a tax-supported government institution may be reimbursed by IDPA for professional services rendered to IDPA recipients, provided such services are performed outside the tax-supported government institution.
2. Non-salaried attending physicians of IDPA recipients in tax-supported government hospitals may be reimbursed by IDPA—on an individual basis—for professional services rendered to IDPA recipients.
3. If a non-tax supported hospital does not include the physicians salaries in its billings to IDPA, full time and part time salaried physicians may be reimbursed by IDPA for professional services rendered to IDPA recipients who are their private patients. If the physicians' salaries are included in the hospital billings to IDPA, the physicians should not be reimbursed by IDPA.

Procedures for payment for out-patient services were referred back to the Advisory Committee for further study.

## STATEWIDE REGISTRY OF MATERNAL AND PERINATAL MORTALITY

The Board concurred in the recommendation of a special Ad Hoc Committee that ISMS undertake a special five year study to register all perinatal deaths in Illinois. An appropriate com-



mittee will be activated to conduct this study if the necessary funds and cooperation of the hospitals and the Department of Public Health can be obtained.

#### HOSPITAL EXPANSIONS

Following a meeting between the ISMS Executive Committee and representatives of the Illinois Hospital Association, the Board voted to oppose Senate Bill 1145 which would require hospitals to obtain a permit from the Department of Public Health to expand facilities. This in effect would provide for mandatory hospital planning under the authority of the hospital licensing board and the Department of Public Health. Further discussions with the Illinois Hospital Association and the Department of Public Health will be conducted. Other facets of hospital planning were discussed with no specific Board action being taken.

#### LEGISLATION

In action on the report of the Council on Legislation and Public Affairs, the Board:

Opposed H-2495 to amend the insurance code making it mandatory for chiropractors to be paid by third party carriers;  
Opposed laboratory bill H-2531 which would add chiropractors to the Clinical Laboratory and Blood Bank Licensing Board;  
Opposed H-2540 reducing the requirement for Director of Laboratories and requiring the dual licensure of physicians who do laboratory work in their own office;  
Opposed S-890 and S-1107 which would license electrologists and hearing aid dealers and fitters respectively;  
Opposed H-1084 which would allow attorneys to inspect hospital records.

#### DR. JIRKA RE-ELECTED CHAIRMAN

By official action, Dr. Frank J. Jirka, Jr., River Forest, was re-elected chairman of the Board.

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## Meeting Memos

### August 9—Illinois State Medical Society

*5th Annual Athletic Injury Clinic*  
Union Building, Northern Illinois University, DeKalb

### August 10-15—American Congress of Rehabilitation

*46th Annual Session*  
Palmer House, Chicago  
"Application of Computers in Rehabilitation Medicine"  
"Behavior Analysis Systems in Medical Rehabilitation"

### August 15-17 — The Comprehensive Medical Society

*Sex Education Conference*  
Conrad Hilton Hotel, Chicago  
"Where Should We Go In Sex Education—A Search For Perspectives"

### August 18-21—American Hospital Association

International Amphitheatre, Chicago

### August 18-22—University of Chicago

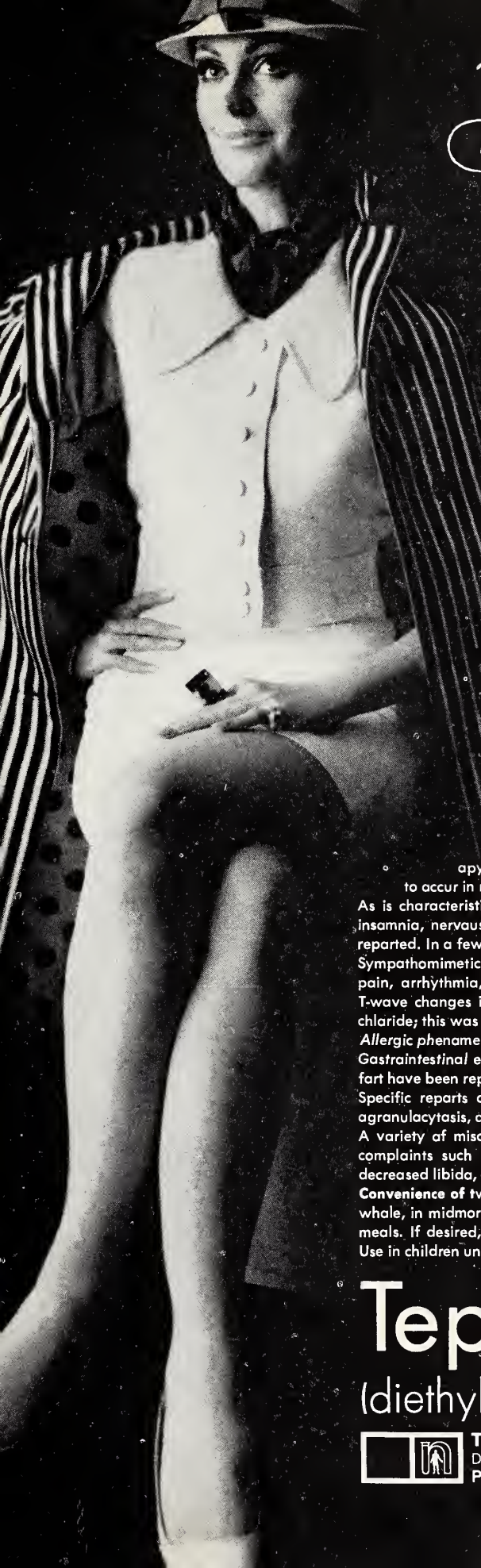
*Third International Tutorial on Hormonal Cytology*  
Center For Continuing Education, 1307 East 60th St., Chicago

### August 21-22—American Medical Association

*Communications Institute*  
Drake Hotel, Chicago

### August 24-29—International Association of Gerontology

*8th International Congress*  
Sheraton Park and Shoreham Hotels, Washington D.C., and Baltimore, Maryland



*Dear Doctor,  
You made me  
what I am today—  
a whole lot  
slimmer!*

**TEPANIL**—the right start in support of the weight-control program you recommend. It reduces the appetite. Doesn't kill it. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation. Because **TEPANIL** works on the appetite, not on the "nerves."

**Contraindications:** Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

**Warning:** Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

**Adverse Reactions:** Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence.

As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported.

Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others.

Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported.

Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia.

A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

**Convenience of two dosage forms:** **TEPANIL** Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); **TEPANIL**: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midafternoon to overcome night hunger. Use in children under 12 years of age is not recommended.

**Tepanil<sup>®</sup> Ten-tab<sup>®</sup>**  
(continuous release form)  
(diethylpropion hydrochloride)



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PHILADELPHIA, PENNSYLVANIA 19144

T-918A

U.S. PATENT NO. 3,001,910

5/69



# Recommended Dietary Allowances

BY W. H. SEBRELL, JR., M.D./NEW YORK

The Recommended Dietary Allowances were first published in 1943 and have been revised approximately every five years as advances in knowledge provided data for making better estimates. They have become the accepted guide for the United States.

It is important to keep in mind the purposes of the Recommended Dietary Allowances. If their purpose is misinterpreted, one is led to the erroneous conclusion that the Recommended Dietary Allowances are too high. They are set at levels which will maintain good nutrition in practically all healthy persons in the United States and are intended to serve as goals in planning food supplies and as guides for the interpretation of food consumption records of groups of people. It is important to stress that since the recommendations are intended to meet the full needs of practically everybody, they will be considerably higher than some persons will need.

The Recommended Dietary Allowances should not be interpreted as nutritional requirements for individuals. However, they may be used as recommended allowances for individuals with the clear understanding that the amounts recommended may be in excess of the individual requirement. The important point is that it must not be assumed that an individual will suffer from malnutrition if he does not obtain the recommended dietary allowance, and diets must not be called deficient for an individual when he does not obtain the recommended allowances.

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W. H. Sebrell, Jr., M.D., is director, Institute of Nutrition Sciences, School of Public Health and Administrative Medicine, Columbia University, New York City. A graduate of the University of Virginia School of Medicine, Charlottesville, Dr. Sebrell is a member of the American Board of Preventive Medicine, the American Academy of Pediatrics and the American Society for Clinical Investigation.

A second point that should be noted is that the Recommended Dietary Allowances are intended for use in the United States, under current conditions of living. They, therefore, take into account the climatic conditions, the economic status, the distribution of the population and various other factors which make the Recommended Dietary Allowances particularly suitable for the United States.

## Allowances Serve As References

They are a valuable reference for experts in other countries in arriving at suitable recommended dietary allowances for their own countries. Previous editions of the Recommended Dietary Allowances have consisted of two parts—the first being a list of recommended dietary allowances and the second a consideration of nutrients not tabulated. In the present (seventh) edition, nutrients not previously tabulated have now been given specific recommended allowances. These are vitamin E, folacin, vitamin B<sub>6</sub>, B<sub>12</sub>, phosphorus, magnesium and iodine. Some changes were also made in the age categories. Males and females are separated from age 10 months onwards and a new category for 18 to 22-year-olds has been added. Infants under one year of age are now tabulated in three groups from birth to two months—two months to six months—and six months to one year of age.

For purposes of estimating a Recommended Dietary Allowance for calories, a "reference man and reference woman" was used in the 1953 edition. They were described as 25 years of age, weighing 143 and 121 pounds respectively. In this and

*This is the third in a series of five papers being presented from the Symposium on Nutrition conducted in February, 1969, co-sponsored by ISMS through the Nutrition Committee.*



other revisions, the "reference man and reference woman" were changed to 22 years of age, weighing 154 and 128 pounds respectively. The age was changed to 22 years since there is evidence that weight gain after this age is likely to be fat. In the 1964 edition, considerable attention was called to the fact that there was a reduction in the recommended calorie allowance to 2,900 kcals for man and 2,100 kcals for the woman. In the present revision, these daily allowances have been reduced by another 100 calories to 2,800 calories and 2,000 kcals respectively. This is a realistic interpretation of energy expenditure by the "reference man and reference woman" in the United States.

### **Dietary Surveys**

The Department of Agriculture has, in the past, made several important dietary surveys. The latest of these covers data collected in the spring of 1965. These data indicate that a considerable number of households in the United States do not come up to the Recommended Dietary Allowances in the quality of their diets. For example, about 20% of the households had diets that supplied less than two-thirds of the Recommended Dietary Allowance for one or more nutrients and this is an increase of about 5% over a similar study done in 1955. The nutrients that most often failed to meet the Recommended Dietary Allowances were calcium, vitamin A and ascorbic acid, which were associated with the use of less than recommended amounts of milk, milk products, vegetables and fruits. Status of income indicated that the successively higher levels of income resulted in a greater percentage of households having diets that met the Recommended Dietary Allowances, but high income alone was no assurance of good diets since the incomes of \$10,000 and higher still had 9% of the households with less than two-thirds of the Recommended Dietary Allowances for one or more nutrients.

While these data are interesting, they do not give us any indication of the effects of these household diet figures on the individuals concerned and in the production of symptoms of malnutrition.

At the present time an extensive series of nutritional studies are being conducted in various parts of the United States, in which clinical, anthropometric and bio-

chemical studies are being carried out, in order to determine the actual prevalence of malnutrition, especially in low income groups.

### **Public Health Study**

Dr. Arnold E. Schaefer, of the Public Health Service, reported to a Senate Committee in January, 1969, that on the basis of preliminary findings, after complete physical examination of 12,000 Americans, selected in low income areas of Texas, Louisiana, New York and Kentucky, there was an alarming prevalence of disease commonly associated with undernourishment. He stated that the nutritional level of the people examined was as low as that found in similar surveys in Central America. His findings included seven cases of marasmus and kwashiorkor, 18 cases of rickets and 5% of the people examined had goiter, which is the level at which goiter is considered endemic.

Another important finding reported by Dr. Schaefer is a high incidence of growth retardation and in his sample, the children between the ages of one and three years fall below the average height reported for children in the United States. Bone x-rays of these children indicated that 3½% were physically stunted. One-third of the children of six years of age were anemic and one-third had low levels of vitamin A, with about 13% so low as to constitute what he calls a high risk category.

From less complete studies on similar groups in various areas, one can predict that considerable malnutrition will be found in very low income groups, especially in the slums and poor rural areas of this country. This situation seems almost unbelievable in a nation as prosperous as this one, and especially in view of the large amounts of food that are being exported.

However, the basic problem here is the same as it is in other parts of the world. There is always a financial gap between the money available to low income groups and the price that has to be charged for food, in order for the producer and processor to make a fair profit. As you are aware, we have made an effort in this country to bridge this gap by two principal devices—the school lunch program and the use of the food stamp plan. In addition, there has been a massive and continuing effort

at education by a large number of agencies, both federal and state, designed to teach people the fundamentals of good nutrition and how to get the best nutrition for their food money.

### **Prerequisite Steps**

There are several things that need doing, which are already under consideration, or which can be accomplished relatively quickly. One of these is to improve the school feeding program by making a nutritious lunch available to every school child in the country, regardless of economic status. Those children who do not have the money to pay for a school lunch are most likely the ones that are in greatest need of the lunch. It is certainly within our economic reach to provide a lunch for school children who cannot afford to pay for it. The lunch needs to be nutritionally sound and should not be based on surplus commodities but on what is needed to supply good nutrition to school children. Similar programs should be developed for infant day care centers, wherever children are brought together in kindergartens, play schools, or in centers for children whose mothers are working. A meal should be provided, designed to meet the nutritional needs of the children. Infant foods should be provided for mothers who have to wean their children and who cannot afford to buy the necessary foods for the child's good health.

The food stamp plan is really a second form of currency which is designed to bridge the economic gap between the income of the impoverished and the price that must be charged for the food. It enables the recipient to buy selected foods at

a considerable reduction in cost to him, the difference being subsidized from government sources. This scheme has not been extensive enough and has not been handled in a way that brings these food stamps into the hands of the people who need them the most.

The entire system needs to be developed and expanded. The advantage of this system is that it enables the individual to buy food at the local grocery through the regular commercial channels of trade and at the same time, it would supply a subsidy to the food producer and processor, since it would greatly increase the market for nutritional food and avoid government channels of food distribution.

There is one other element that needs serious consideration. Our present system, as handled by the Department of Agriculture, is based primarily on distribution of surplus foods. Thus, the Department is inclined to supply foods on a surplus basis, rather than on the basis of nutritional need of the individual. In my opinion, the Public Health Service, in the Department of Health, Education, and Welfare, should be empowered to set the nutritional standards to be met in all efforts to alleviate malnutrition in this country, with the Department of Agriculture charged with making the food available, and distribution made in accordance with the standards set by the Public Health Service. It would also be essential that the Public Health Service do repeated and continuing nutritional surveys as a means of determining the effect of these programs, and institute changes in the programs where such need was demonstrated. ◀

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### **MARRIAGE PAMPHLET AVAILABLE**

Most couples enter marriage confident that they are embarking on a long and happy life together. For many, that is true. Still, distressing problems often arise in the first years; and whether the marriage will continue happy and rewarding or will become hostile and unbearable depends, to a great extent, on how the early difficulties are met and resolved.

#### **THE EARLY YEARS OF MARRIAGE,**

by Richard H. and Margaret G. Klemer, is a new Public Affairs Pamphlet that offers guidance for this important period. The Klemers are on the faculty of the University of North Carolina at Greensboro, teaching family relations and maternal and child nursing, respectively. Their pamphlet is available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York, N.Y. 10016.

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## Film Reviews

Rehabilitation of the hard narcotics user is the central theme of the third and final film in "The Distant Drummer" documentary series on drug abuse. The film, which provides a sociological backdrop for the entire drug problem, is being distributed by the National Association of Blue Shield Plans for showing by Blue Shield plans, medical societies and the television industry. For further information contact: Natl. Assoc. of Blue Shield Plans, 211 E. Chicago Ave., Chicago 60611.

Smith Kline & French Laboratories has recently released its 9th Annual **Services Catalog**. The new edition offers 50 pages of SK&F services available to physicians without charge. Included in the catalog are medical films, booklets, periodicals, Speakers Bureau, and the "Code 4" cardiopulmonary resuscitation training program. Copies may be obtained from: Services Dept. E-10, SK&F, 1500 Spring Garden St., Philadelphia, Pennsylvania 19101.

### When Silence Is Golden

"If you cannot improve on silence, don't say anything."—Sen. Edmund S. Muskie of Maine.



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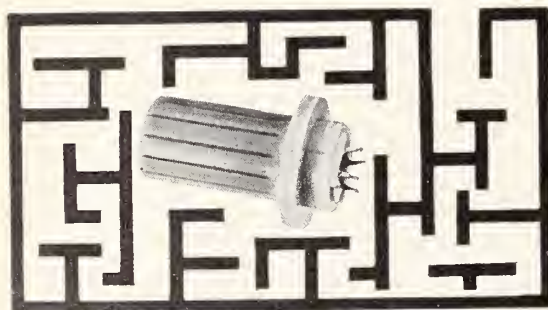
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### Alcoholic and Drug Addiction Cases Accepted

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(Rosenthal)

**Precautions**—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).



LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

473-9

## NEW PHARMACEUTICAL SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturer's package insert or brochure.

**Single Chemicals:** Drugs not previously known, including new salts.

**Duplicate Single Products:** Drugs marketed by more than one manufacturer.

**Combination Products:** Drugs consisting of two or more active ingredients.

**New Dosage Forms:** Of a previously introduced product.

### SINGLE CHEMICAL ENTITIES

**KONYNE:** Biological R  
**Manufacturer:** Cutter Laboratories

**Nonproprietary Name:** Factor IX complex (human)

**Indications:** Factor II, VII, IX (hemophilia B) or X deficiencies.

**Contraindications:** Cases of known liver disease where there is any suspicion of intravascular coagulation of fibrinolysis.

**Dosage:** Must be individualized.

**Supplied:** Bottles—500 units.

### COMBINATION PRODUCTS

**ARIDOSE** Nasal Decongestant R  
**Manufacturer:** Savage Laboratories

**Composition:** Each cc. contains:

Atropine sulfate	0.2 mg.
Chlorpheniramine maleate	5.0 mg.
Phenylpropanolamine HCl	12.5 mg.
Benzyl alcohol	1.5%

In water for injection

**Indications:** Symptomatic relief of nasal congestion and hypersecretion.

**Contraindications:** Hypertension, hyperthyroidism, organic heart disease, severe diabetes mellitus, glaucoma or prostatic hypertrophy.

**Dosage:** 0.5 to 1.0 cc., i.m. or s.c.

**Supplied:** Vials—10 cc.

**EL** Eye Preparation R

**Manufacturer:** Person & Covey, Inc.

**Composition:**

L-Epinephrine bitartrate	1.0%
Chlorobutanol	0.25%
Benzalkonium chloride	0.01%

**Indications:** Open angle glaucoma.

**Contraindications:** Narrow angle glaucoma.

**Dosage:** One drop in eye as needed.

**Supplied:** Solution—bottles of 15 cc.

**NIORIC S.R.** Psychostimulant R

**Manufacturer:** B. F. Ascher & Co.

**Composition:**

Pentylentetrazol	300 mg.
Niacin	150 mg.

**Indications:** Aged patient, mildly confused, forgetful, depressed, anti-social, due to cerebrovascular insufficiency.

**Contraindications:** Epilepsy.

**Dosage:** One tablet, q. 12h.

**Supplied:** Tablets, sustained release—bottles of 100 & 500.

(Continued on page 108)

## Obituaries

Persons wishing to do so may make contributions to the ISMS Educational and Scientific Foundation to honor the memory of a member who has died. Members of the family will be notified that such a contribution has been made and the name of the donor will be supplied.

Checks should be addressed to Educational and Scientific Foundation, ISMS, 360 N. Michigan Ave., Chicago 60601.

**Dr. John V. Adams**, Geneseo, died May 3 at the age of 62.

**\*Dr. L. Paul Bunchman**, Freeport, died May 15. He was a past president and past secretary of the Stephenson County Medical Society.

**Dr. Erich H. Bukofzer**, Chicago, died Dec. 27 at the age of 74.

**\*Dr. Dudley T. Dawson**, Lincoln, died March 25. He was a member of the ISMS Fifty-Year Club.

**Dr. Chester J. Farmer**, Cedar Lake, Ind., died May 7 at the age of 82.

**\*Dr. Frank C. Green**, Chillicothe, died May 11 at the age of 67. He was president of the Methodist Hospital staff.

**\*Dr. George N. Green**, Elgin, died May

14 at the age of 70.

**\*Dr. Harry T. Haver**, Park Ridge, died May 15 at the age of 63.

**\*Dr. James M. Head**, Evanston, died May 27 at the age of 43.

**Dr. Abraham L. Hollender**, Chicago, died May 7 at the age of 77. He edited the *Eye, Ear, Nose and Throat Monthly*.

**\*Dr. Max Meyerovitz**, Chicago, died May 14 at the age of 84. He was a member of the ISMS Fifty-Year Club.

**Dr. Gerhardus Stuart, Jr.**, Palos Heights, died Jan. 10 at the age of 90.

**\*Dr. John C. Wall**, Chicago, died June 2 at the age of 63. He was past president of the Englewood Branch of the Chicago Medical Society and a retired member of the Society's Credentials Committee.

*\*Indicates member of Illinois State Medical Society.*

**\*Dr. Hjalmar L. Wallin**, Melrose Park, died May 8 at the age of 81.

**Dr. William B. Welch**, Barrington, died May 8 at the age of 50.

**\*Dr. Bruno J. Zubrick**, Chicago, died Dec. 25 at the age of 66.

# HIGHLAND HOSPITAL

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High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

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or

Charles W. Neville, Jr., M.D.

Assistant Professor of Psychiatry and Medical Director

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**COOK COUNTY**  
**Graduate School of Medicine**  
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SPECIALTY REVIEW COURSE FOR FAMILY PRACTICE, July 21  
 SPECIALTY REVIEW COURSE IN SURGERY, Part I, August 11  
 SPECIALTY REVIEW COURSE IN THORACIC SURGERY, Sept. 15  
 SPECIALTY REVIEW COURSE IN MEDICINE, Part I, Sept. 15 & 29  
 PATHOLOGY REVIEW COURSES FOR SPECIALTIES, Request Dates  
 PROCTOSCOPY & VARICOSE VEINS, One Week, Sept. 9  
 ADVANCED HAND SURGERY, Three Days, Sept. 9  
 SURGERY OF HEAD & NECK, One Week, Sept. 15  
 SURGERY OF STOMACH & DUODENUM, One Week, Sept. 15  
 SURGERY OF COLON & RECTUM, One Week, October 13  
 ADVANCES IN SURGERY, One Week, August 25  
 VAGINAL APPROACH TO PELVIC SURGERY, One Week, Sept. 15  
 ADVANCES IN GYNECOLOGY & OBSTETRICS, One Week, Sept. 29  
 PEDIATRIC SURGERY, One Week, Sept. 29  
 DIAGNOSTIC RADIOLOGY, One Week, Sept. 15  
 RADIOISOTOPES, One or Two Weeks, Request Dates  
 DERMATOLOGY, One Week, October 6

*Information concerning numerous other continuation courses available upon request.*

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**ACHROMYCIN® V**  
**TETRACYCLINE HCl**



## New Pharmaceutical Specialties

*(Continued from page 106)*

**SPAR-CAL Vitamin-Mineral Comb.** o-t-c

**Manufacturer:** Mead Johnson Laboratories

**Composition**

Calcium (as carbonate) 500 Mg.  
 Vitamin D<sub>2</sub> 200 USP units

**Indications:** Dietary supplement.

**Contraindications:** None mentioned.

**Dosage:** Adults and older children: 1 to 2 tab. in 6 oz. water. Children under 3 yrs.: as directed by physician.

**Supplied:** Effervescent tablets—foil wrapped, boxes of 30.

### NEW DOSAGE FORMS

#### ERYTHROCIN SUPPOSITORIES

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**Manufacturer:** Abbott Laboratories

**Nonproprietary Name:** Erythromycin

**Indications:** Infections due to erythromycin-susceptible organisms, when oral therapy is not tolerated.

**Contraindications:** Hypersensitivity to the drug.

**Dosage:** Children up to 20 lbs.: 125 mg. q. 8h.  
 Children 20 to 40 lbs.: 125 mg. q. 6h.

**Supplied:** Suppositories—125 mg., packages of 12.

### An Oldtimer Is One Who:

Remembers when the village square was a place—not a person.

Remembers when the wonder drugs were mustard plasters and castor oil.

Can remember when he could remember.

Remembers when rockets were just part of a fire-works celebration.

Can remember when folks sat down at the dinner table and counted their blessings instead of calories.

Turned out the gas while courting instead of stepping on it.

Can remember when Sunday drivers let off steam by shaking their buggy whips at each other.

Can remember when a bureau was a piece of bedroom furniture.

Can remember when the woman he left behind stayed there.

Remembers when a dishwashing machine had to be married—not bought.

Can remember when any man who washed dishes worked in a restaurant.

### The Tall State

Illinois' largest city—Chicago—share's \$36.6 billion of the nation's gross national product which almost equals Italy's GNP, exceeds that of all four Scandinavian nations and is nearly three-fourths of Canada's GNP.



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472-9

## THE VIEW BOX

(Continued from page 49)

**Diagnosis:** Atelectasis of the left lower lobe.

The left lower lobe collapses downward posteriorly and medially toward the spine and retains its connection with the hilus through a tongue of opaque lung tissue that has been called the mediastinal wedge. In the PA view the concave border of the collapsed segment is readily identified behind the cardiac shadow. The left hilus is down in its position. (It should ordinarily be slightly elevated when compared to the right hilus). There has been an over expansion of the left upper lobe and it extends down the lateral aspect of the left hemidiaphragm. The left border of the lower dorsal spine and descending aorta are obscured because of the posterior position of the collapsed lower lobe which creates a positive silhouette sign obscuring structures which might normally be seen in this location. On the lateral examination the right hemidiaphragm is readily identified running from anterior to posterior. However, only a small portion of the left diaphragm is noted at the mid-third. The anterior third is obliterated by the heart and the posterior third by the airless lower lobe. The lower vertebral bodies appear slightly denser than those above because of the overlying collapsed segment. Incidentally noted is a double density along the right heart border which represented a left atrium which was not enlarged in this case.

### Reference:

FUNDAMENTALS OF CHEST ROENTGENOLOGY. Felson;  
W. B. Saunders, pp. 85-98.

## Membership Forum

(Continued from page 85)

Delegates supported the establishment of local public health departments on a county or multi-county basis, noting that there are 38 counties now without health departments and 24 counties with only limited public health services.

Last, but far from least in the society's departure from former positions, was the adoption of a resolution opening membership in the society to osteopaths, and urging medical school courses in patient care costs.

Such actions, one might observe, are a further evidence of the coming of age of the 129-year-old society. We applaud."



# BLUE SHIELD REPORT



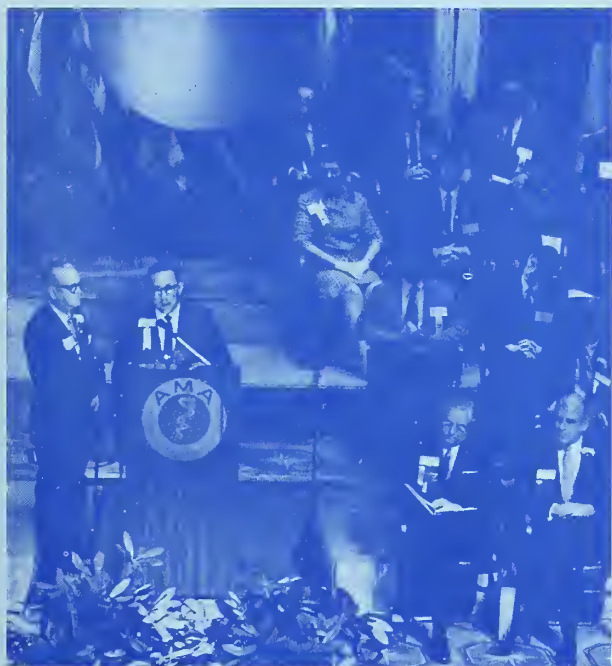
## FOR *Illinois Physicians*

PUBLISHED MONTHLY BY: BLUE SHIELD PLAN OF ILLINOIS MEDICAL SERVICE • 222 NORTH DEARBORN ST. • CHICAGO, ILLINOIS 60601

Vol. 3, No. 8

August, 1969

### AMA Elects Illinois M.D.'s to High Posts



At the annual convention of the American Medical Association in New York City, July 13-17, two members of the Board of Trustees of the Blue Shield Plan of Illinois Medical Service were elected to high posts.

Walter C. Bornemeier, M.D., Chicago, became President-Elect of the American Medical Association. Doctor Bornemeier who practices surgery has served on the Board of Trustees of the Blue Shield Plan of Illinois Medical Service since 1953. In 1963 at the annual convention of the American Medical Association in Atlantic City, Doctor Bornemeier was elected Vice-Speaker of the House of Delegates where he served for three years. He was elected Speaker of the House in 1966 and has served in that capacity ever since.

Burtis E. Montgomery, M.D., Harrisburg, who also is a member of the Blue Shield Board, was re-elected to the Board of Trustees of the AMA where he has served as its Chairman. Doctor Montgomery has served on the AMA Board since 1966 and on the Board of Trustees of Blue Shield since 1958. He was President of the Illinois State Medical Society in 1966 and was Chairman of its

Board of Trustees from 1958 to 1960. Doctor Montgomery practices internal medicine in Harrisburg.

He is shown in the above photograph during the opening ceremonies of the House of Delegates while presenting an award to "the astronauts' physician," Doctor Charles Berry. Seated in the front row on the right side is Doctor Walter C. Bornemeier reviewing the order of business of the House.

### Scheduled Workshops for Medical Assistant

The fall dinner-workshops for medical assistants in the Counties of Cook, Kane, Lake, Will and DuPage will begin September 3 at Pheasant Run Lodge in St. Charles, Illinois.

The workshops are intended to aid medical assistants in carrying out their responsibilities more effectively for their physician-employers and to keep them abreast of changes in Blue Shield benefits and ways to file Physician's Service Report forms to prevent delays in payment.

All medical assistants will be invited to attend one of the scheduled workshops and should return promptly the reservation form they receive with their invitations.

<i>Date</i>	<i>Place</i>	<i>Area</i>
September 3	Pheasant Run Lodge	Kane County
September 4	Pheasant Run Lodge	Kane County
September 10	Henric's, Oak Brook	DuPage County
September 11	Ramada Inn, County Line	DuPage County
September 17	Waukegan Inn	Lake County
September 18	Waukegan Inn	Lake County
September 24	Holiday Inn, Joliet	Will County
September 25	Howard Johnson, Joliet	Will County
October 1	Neilson's Nordic	Southwest Chicago
October 8	Oak Park Arms	West Chicago
October 22	Arlington Park Towers	Northwest Suburban
October 29	Hyatt House	Northwest Chicago
November 12	Knickerbocker Hotel	Loop
November 13	Knickerbocker Hotel	Loop

Workshops are conducted in the spring and early summer for medical assistants residing in countries other than those listed above.

For additional information, please write or call Mrs. Loretta O'Donnell, Professional Relations Representative, Professional Relations Department, Blue Shield Plan of Illinois Medical Service, 222 North Dearborn Street, Chicago, Illinois 60601. Telephone (312) 661-2964.

*(This is not an advertisement)*



## ASK BLUE SHIELD

### • • • ABOUT MEDICARE

## Durable Medical Equipment

Medicare regulations allow your patient to be reimbursed for the rental or purchase of durable medical equipment. The decision to rent or to purchase the equipment is made by the patient.

If your patient decides to purchase, monthly installment payments will be made either to him or to the supplier, if he accepts an assignment, in an amount not to exceed the monthly rental of the equipment.

Payment may also be made under this provision for repairs, maintenance, and delivery of the equipment as well as expendable and non-reusable materials essential in the use of the equipment.

Medicare's definition of durable medical equipment is equipment which (a) "Can withstand repeated use, *and* (b) is primarily and customarily used to serve a medical purpose *and* (c) generally is not useful to a person in the absence of an illness or injury."

To enlarge on this definition, an item will be considered durable if it can withstand repeated use, i.e., the type of item which could normally be rented. Medical supplies of an expendable nature such as irrigating kits, catheters or disposable bags do not fall into the category of "durable."

An apparatus must not only be "durable" but it must be of a "medical" nature. That is, equipment "which is primarily and customarily used for medical purposes and is not generally useful in the absence of illness." Equipment which would be of value to a patient but is "primarily and customarily used for a non-medical purpose" is not in benefit. For example, an air conditioner might be used to lower room temperature to reduce fluid loss and to restore an environment conducive to convalescence. Nevertheless, because the primary and customary use of the air conditioner is non-medical, payment for it cannot be allowed under Medicare. Other environmental control devices, such as electric air cleaners, dehumidifiers and humidifiers are not covered. Also, the purchase or rental of physical fitness equipment, comfort or convenience equipment, self-help devices, first aid or precautionary equipment and training equipment are not reimbursable under Medicare.

Equipment which does meet the criteria of "durable" and "medical" is reimbursable under Medicare but only if it is also "necessary and reasonable," i.e., the equipment must be "necessary" for the treatment of an illness or injury or to improve the functioning of a malformed body member. It must also be considered reasonable therapeutic treatment for the given condition of your patient and not substantially exceed the basic level of treatment necessary to correct the patient's condition. In most situations the physician's prescription is all that is required to meet the reasonable and necessary criteria.

Under certain conditions equipment which normally would not be considered durable medical equipment because it is primarily not used to serve a purpose and is useful in the absence of illness or injury is reimbursable. Such equipment would be reimbursable under Medicare if it can be clearly established that it is serving a therapeutic purpose in an individual case. Such situations include: (1) Bed bath equipment for a bed-ridden patient which is used for therapeutic purposes rather than for personal hygiene, e.g., when the patient requires baths in medicated solutions; (2) Gel pads and pressure pads prescribed for a patient who has "decubiti" or there is medical evidence indicating that he is highly susceptible to such ulceration; (3) Sun lamps for a medical rather than a cosmetic purpose.

Items of this nature require evidence that they are being used under the supervision of the physician.

Basically, durable equipment is reimbursable if: (a) The equipment meets the definition of durable medical equipment; (b) The equipment is necessary and reasonable for the treatment of the patient's illness or injury; (c) The equipment is used in the patient's home; (d) The equipment is prescribed by the patient's physician.

### Our Government Contracts Division

reports that Federal Health Insurance benefits under Title XVIII, Part B of P.L. 89-97 were paid during June for over 68,000 cases in the counties of Cook, DuPage, Kane, Lake and Will for an amount exceeding \$4,000,000. For the year 1969 through June, payments have been made on over 300,000 cases for over \$25,000,000.

The number of cases processed in June under Part A exceeded 77,000 with payments to providers amounting to more than \$24,000,000. For the year 1969 through June, over 407,000 cases have been processed and payments to providers have exceeded \$153,000,000.



Edward W. Cannady, M.D.

# The President's Page

## DEADLINE FOR OPINION SURVEY

A year ago more than 3,000 of our members took time from their busy schedules to complete the Society's first Membership Survey on Socio-Economic issues. Thus, nearly one third of ISMS members had a direct voice in choosing the path our Society would follow.

Earlier this month, a new Opinion Survey was sent to you. You are again being asked to express your views on what direction ISMS should take in the year ahead.

If you have not yet returned the survey, please do so immediately. Your answers will be a mandate to ISMS leaders and will exert a powerful influence on the course of medical practice and public affairs within our state and nation.

### **Results Provide Guidelines**

Last year's survey brought a wealth of results that not even our leadership foresaw. To mention just a few:

- \* It persuaded your House of Delegates to call for legalization of certain forms of therapeutic abortion in Illinois. Previously the House had resisted taking a stand.
- \* It prompted closer ties with osteopaths . . . greater voluntary activity in medically-deprived areas . . . other important measures.
- \* It guided ISMS committees into undertaking new projects . . . provided material for speeches on the President's Tour—and, became the basis for in-depth articles in the *Illinois Medical Journal*.
- \* It brought us nationwide publicity, prompted several other state societies to plan similar surveys, and kept

ISMS in the forefront in organized medicine.

### **Vital Issues At Stake**

The 1969 survey seeks your opinion on such vital issues as artificial insemination—stronger anti-chiropractic legislation—revocation of license for unethical practice—reduced payments from medicaid—compulsory participation in continuing medical education programs—and providing health centers in deprived areas.

These and other provocative subjects covered in the questionnaire are making headlines throughout the country. More than ever before, your ISMS leaders need guidance to steer a proper course through the crucial period ahead.

I hope your response to this survey will surpass the 1969 results. I would like to see 100% cooperation from our membership.

### **A Team Approach**

It's obvious what ISMS can do when it acts as a single unit—as a team. We represent one of the most powerful forces in the state—but only if we work together.

I hope each of you will take a few minutes to complete the Opinion Survey and return it to our state office where results will be computed. Your cooperation is vital to the future of organized medicine in Illinois.

*Edward W. Cannady*



**Description:** FLUOGEN (Influenza Virus Vaccine, Bivalent, Ether Extracted Antigen) (Types A2 and B) is composed of the antigen of the strains of influenza viruses recommended by the Division of Biologics Standards, National Institutes of Health, Public Health Service. It is formulated to contain 400 CCA (chick cell agglutination) units of extracted immunizing antigen of type A2/Aichi/2/68 strain (Hong Kong variant) and 300 CCA units of extracted immunizing antigen of B/Massachusetts/3/66 strain for a total of not less than 700 CCA units per each 0.5 cc. dose.

**Method of Preparation:** The influenza viruses are propagated on developing chick embryos. The extra-embryonic fluid containing the virus suspension is harvested, clarified by filtration and concentrated and refined by ultracentrifugation. Polysorbate-80, U.S.P. (175 mcg. per 0.5 cc.) is added to the refined concentrate. The refined concentrate is extracted with ethyl ether, stabilized with formalin, and preserved with 0.01% thimerosal (mercury derivative). The vaccine contains not more than 1:12,000 formalin, used during the process. It does not contain penicillin. Aluminum phosphate, 1.5 mg. per 0.5 ml. is added to the vaccine as an adjuvant.

**Indications:** FLUOGEN is indicated for the production of immunity to influenza produced by the strains of virus containing antigens related to those in the vaccine. FLUOGEN is recommended primarily as a seasonal booster for persons who were previously vaccinated with vaccines containing the A2 Hong Kong variant. It may also be used for primary immunization of those who have not previously received the Hong Kong variant. It is recommended that both primary and booster immunization be completed by early December since influenza is more likely to appear during cold weather. It is understood that should epidemic conditions be predicted, immunization procedures should be initiated regardless of the time of year. Attempts to produce immunity following the appearance of an epidemic may be less successful because of the rapidity with which the disease spreads and the time required for antibody production following vaccination. The degree of protection afforded by immunization with any vaccine may not be sufficient to prevent the disease if the exposure to the influenza virus strains is overwhelming or if the virus strains are not closely related antigenically to those used in the production of vaccine. Although routine vaccination of healthy groups of adults and children is not recommended, when widespread epidemics of influenza are forecast, vaccination may be considered if above-average levels of absenteeism would disrupt satisfactory operations in industries, schools, and other such groups.

**Contraindications:** The use of products prepared from the embryonic fluid of chicken eggs is contraindicated in persons with a history of allergy to eggs, chicken, chicken feathers, or chicken dander. In persons suspected of having an allergic condition, immunization procedures should be preceded by a scratch test or an intradermal injection (0.05 ml. to 0.1 ml.) of vaccine diluted 1:100 in sterile saline to determine possible sensitivity to the minute residual egg protein that may be present in the vaccine. A positive skin reaction contraindicates immunization with the vaccine. Immunization should be deferred in the presence of any acute respiratory disease or other active infection. It should also be deferred in the presence of an epidemic of poliomyelitis unless the risk of influenza represents a greater threat to the patient than the increased possibility of poliomyelitis. **Precautions:** A separate sterile syringe and needle should be used for each patient to prevent transmission of homologous serum hepatitis virus or other infectious agent from one person to another. Reusable glass syringes and needles should be heat sterilized. Epinephrine should be immediately available for use should an acute anaphylactoid reaction occur in individuals having an undisclosed hypersensitivity to any component of the vaccine. Because of the possibility of a febrile reaction following immunization with influenza virus vaccine, the wisdom of attempting to immunize patients with a history of febrile convulsion should be given careful consideration. **Adverse reactions:** Most frequent reaction reported in early clinical studies† with ether-extracted vaccine was tenderness at the site of injection. Headache and malaise were reported in up to about 12% of subjects. Nausea and fever occurred in approximately 5% of the patients. Muscle ache, joint pain, chills, fatigue, and anorexia occurred in less than 5% of the subjects. **Package information:** Bio 579—5 cc. rubber-diaphragm-capped vial. Each 5 cc. vial contains sufficient vaccine to deliver ten 0.5 cc. doses.

†Unpublished data available upon request.

Parke, Davis & Company, Detroit, Michigan 48232

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**FLUOGEN™**  
(influenza virus vaccine,  
bivalent) immunizing  
antigen, ether extracted

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First, we ether-extract our viruses—stripping away a lot of reaction-causing lipids and egg protein in the process.

Then we scrub off more troublemakers with our exclusive gel filtration process.

**Result:** An ultrapure antigen, with the adult dose reduced to 0.5 cc. With this dose, antibody levels are equal or superior to those provided by our conventional influenza virus vaccines but FLUOGEN is **only slightly more than half as likely to cause side effects.\***



## **Northwestern University Medical School**

The Northwestern University Medical School is located on Northwestern's Chicago Campus on the "Near North" side. The Northwestern University Medical Center of which it is a part includes seven member hospitals: Chicago Wesley Memorial Hospital, Children's Memorial Hospital of Chicago, Evanston Hospital, Passavant Memorial Hospital, the Rehabilitation Institute of Chicago, The Veteran's Administration Research Hospital, and the proposed Women's Hospital and Maternity Center of Chicago.

In the photo, the Medical School's 20 story A. Montgomery Ward Building (tower and flagpole) appear at upper left, with the ramp-connected 15-story Searle Building to the right. The seven-story Morton Research Building stands below between them. In the foreground, left to right, are Wesley, Passavant, and the V.A. Research Hospitals. The parking lot beyond Passavant (upper right) will be occupied by the new Women's Hospital and the Rehabilitation Institute of Chicago's proposed new hospital. Northwestern trustees have authorized the University to attempt to obtain the area occupied by the city-owned parking garage, lower center, for future Medical Center use.

Abbott Hall, a student residence hall (headquarters for a World War II U.S. Navy Midshipman School that graduated 20,000 Naval officers, including Pres. John F. Kennedy).

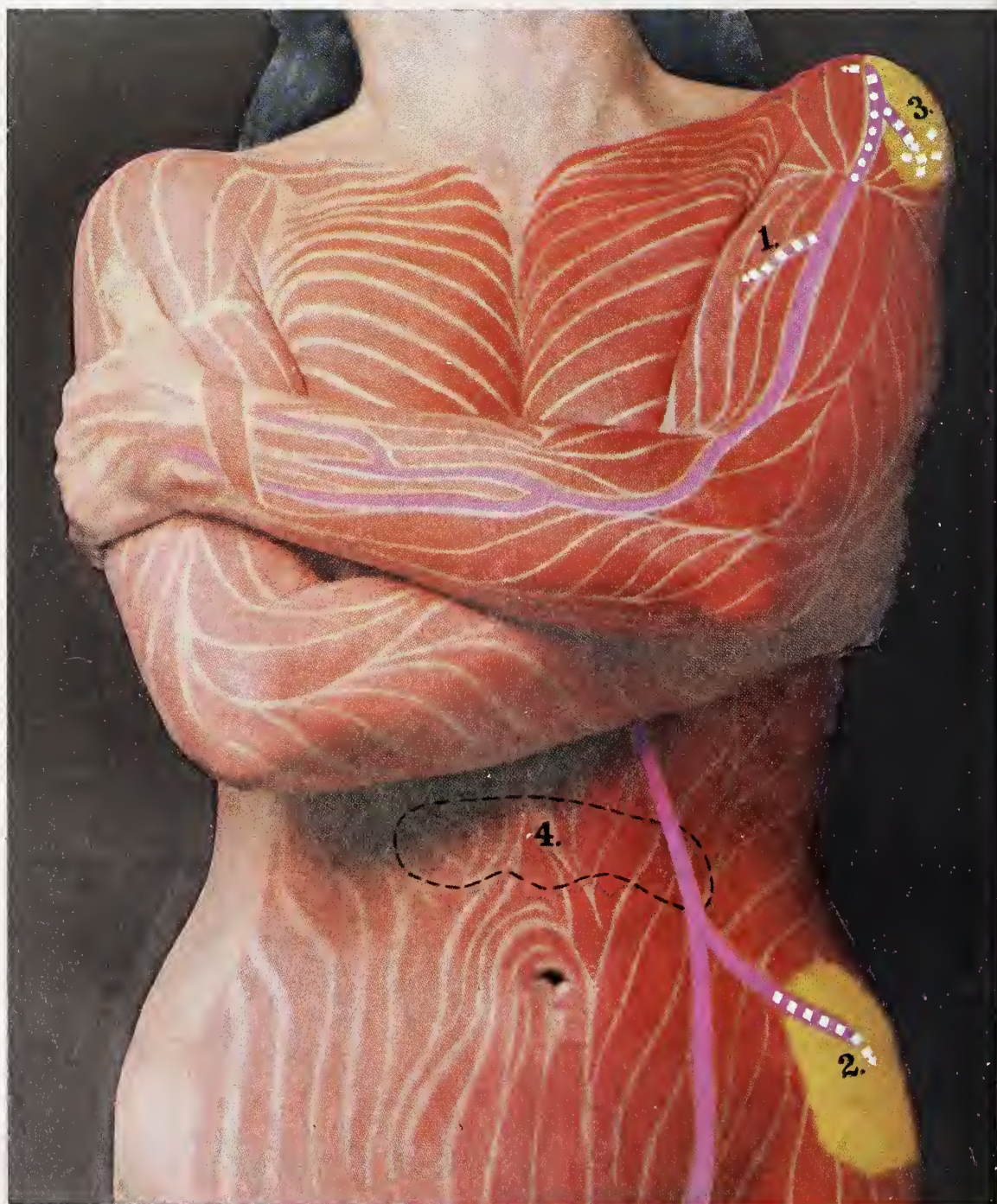
The Medical School was founded in 1859. Among its founders and its first dean was Dr. Nathan S. Davis, the "father" of the American Medical Association. The program of study offered to the students in 1859 was the first graded curriculum established by a medical school. Among its graduates were Drs. Charles Mayo of the Mayo Clinic; Daniel Hale Williams, pioneer heart surgeon; Arthur I. Abt, pediatrician; Joseph B. DeLee, obstetrician; and Frank Billings, long-time dean of the University of Chicago School of Medicine. Dr. James Roscoe Miller, Chancellor of Northwestern; Dr. Theodore R. Van Dellen, editor, *Illinois Medical Journal*; Dr. John A. D. Cooper, president, Association of American Medical Colleges; and Dr. Roger O. Egeberg, newly appointed assistant secretary for health and scientific affairs, Department of Health, Education, and Welfare, are also Northwestern Medical School graduates.

Another graduate, the Northwestern Medical School's Dean, Dr. Richard H. Young, is, with three years' prior service as Dean of the University of Utah School of Medicine. During his tenure as Dean, the regular Medical School budget has grown from \$804,000 to \$3,470,000 plus research and training grants that have grown from \$685,000 to \$6,634,000. The number of full-time positions in the clinical faculty has grown from none to 136.

Under Dr. Young's leadership, the Searle Building's unique interdisciplinary laboratories, in which students perform all their laboratory work at one location, were inaugurated; also, the six-year accelerated program under which talented students can obtain an M.D. degree six years after high school graduation. The Northwestern University Medical Center was organized as a separate legal entity. Federal grants were received to support a new Research and Training Center in Rehabilitation Medicine jointly with the Rehabilitation Institute and to establish a Health Services Research Center jointly with the Hospital Research and Educational Trust of the American Hospital Association. One of the nation's first Biomedical Engineering Centers was organized jointly under an NIH grant with the Northwestern University Technological Institute in Evanston and in various Medical Center hospitals.

Photo courtesy of Northwestern University

**Why DBI-TD (phenformin HCl)  
is the only significant advance  
in oral diabetes therapy  
since sulfonylureas**



□ glucose    ○ insulin



# Carcinoma Multiplex

BY MARVIN F. TIESENGA, M.D., RICHARD H. NEAL, M.D.,  
 AND HENRY W. ROTTSCHAFER, M.D./OAK PARK

Concurrent multiple primary carcinomas, while infrequent, are not a rarity. Since first reported by Billroth in 1879, it has been well documented by many authors. Criteria for multiplicity vary with the author.<sup>1-2</sup> All would agree, however, that each tumor must be distinct, must have malignant cellular morphology, and metastases should be ruled out.

Prompting this report was the simultaneous occurrence of four primary carcinomas, subsequent long term survival, plus certain unique aspects of our patient.

## Report of a Case

February 11, 1964, a pale, jaundiced seventy-two year old man was admitted to West Suburban Hospital. His only complaints were lower abdominal crampy pain and bright red rectal bleeding of two weeks duration. He had no systemic symptoms nor pruritus; except for recent fatty food intolerance his appetite was good; his urine had been amber for several days but the stools were not acholic.

Apart from jaundice and pallor, significant physical findings were limited to the abdomen. He had no cirrhotic stigmata. The abdomen was scaphoid: the liver, smooth and non tender, was readily palpable; so was the spleen.

Hypochromic anemia was reflected in the hemogram: hemoglobin, 9/1 g/100 cc; hematocrit, 31%; red blood cells, 3.67 million/cm. The white and differential counts were normal.

Abnormal chemistries included: LDH, 235; SGOT, 227; SGPT, 152; total protein, 5.5 g/100 cc; (A/G, 1.5/1); total bilirubin, 8.8 mg/100cc; direct bilirubin, 1.2 mg/100 cc; prothrombin time, 23 seconds (control, 13 seconds); alkaline phosphatase, 16 Bodansky units. The cephalan-cholesterol flocculation and thymol turbidity were normal.



Marvin F. Tiesenga, M.D., (left) is a general surgeon. A graduate of the University of Illinois College of Medicine, he is a Fellow of the American College of Medicine and a Diplomate, American Board of Surgery. Richard H. Neal, M.D., received his M.D. degree from the University of

Chicago and is a member of the American Board of Internal Medicine. Henry W. Rottschaffer, M.D., is a graduate of the University of Michigan Medical School, Ann Arbor, as well as a member of the American Academy of General Practice.



A liver scan was interpreted as showing a diffuse nonspecific process.

On peritoneoscopy, the liver was purple-brown without metastases or nodularity. Biopsy showed marked bile stasis suggestive of biliary obstruction.

The patient was transferred to surgery. On exploration, annular lesions with serosal involvement were found at the hepatic and splenic flexures of the colon. A smaller lesion was found in the cecum.

Both the common duct and gall bladder were dilated. A firm, hard, fungating ampullary lesion was exposed and biopsied through a duodenotomy. No metastases were evident either to the liver or lymph nodes.

Priority was given to the colonic lesions and a subtotal colectomy and an ileo descending colostomy were done. Biliary decompression was by cholecystojejunostomy.

Post-operatively he did well and was discharged on the tenth post-operative day.

Microscopically the ampullary lesion was a papillary carcinoma. Each colonic lesion was a separate and distinct adenocarcinoma. All nodes were free of metastases.

Four weeks later he was readmitted for pancreaticoduodenectomy. A clinically inapparent pancreatitis had made the pancreas hard and bulky and seemingly unfit for anastomosis: a total pancreatectomy was done.

Recovery was uneventful. On the sixteenth post-operative day he was discharged on a diet of a small, frequent low fat meals, exogenous pancreatic enzymes, and 35 units of NPH insulin daily. Despite frequent bulky stools his preoperative weight and vigor were regained.

Repeat physical examinations, laboratory work-up and the length of survival suggest that he may be cured.

### Comment

Increasing awareness of multiple primary tumors is evident in the literature. Rae<sup>3</sup> found 8.4% of 711 cases to have multiple lesions. Watson<sup>4</sup> found the incidence to be 7% while Warren and Ehrenreich<sup>5</sup> found an incidence of 6.8%. These figures are consistent with those reported by other investigators (Burke,<sup>6</sup> Moertel, et al<sup>7</sup>). Statistics seem to support the clinical concept that the greatest predisposing factor to cancer development is having had one. Warren and Ehrenreich<sup>5</sup> state that a second is

11 times as probable as a first. These observations and attendant study, however, have done little to unveil the mystery of malignancy.

As stated, our patient had four distinct lesions. Three were colonic—two of which incompletely obstructed the bowel. The fourth obstructed the ampulla of vater. Each lesion was scrutinized in accordance with the criteria of Warren and Gates<sup>2</sup>: each lesion must present definite histopathological evidence of malignancy; each lesion must be distinct; and the possibility of one lesion being a metastasis of another must be excluded. They appeared to satisfy these criteria.

Apparently there is a strong familial carcinoma tendency in a high percentage of patients with multiple carcinomas. Hurt and Broders<sup>8</sup> found an incidence of 44% in other family members. The brother of our patient died of colonic carcinoma. Of interest, his brother had six sons, four of whom are now dead of colonic carcinomas; one is living, apparently cured of colonic carcinoma; the other has had no indication of the problem. Our patient has two children both of whom are apparently cancer free.

### Summary

Multiple simultaneous primary malignancies are unusual but not rare. They are often associated with a strong familial carcinoma tendency. Our patient exhibited this trait.

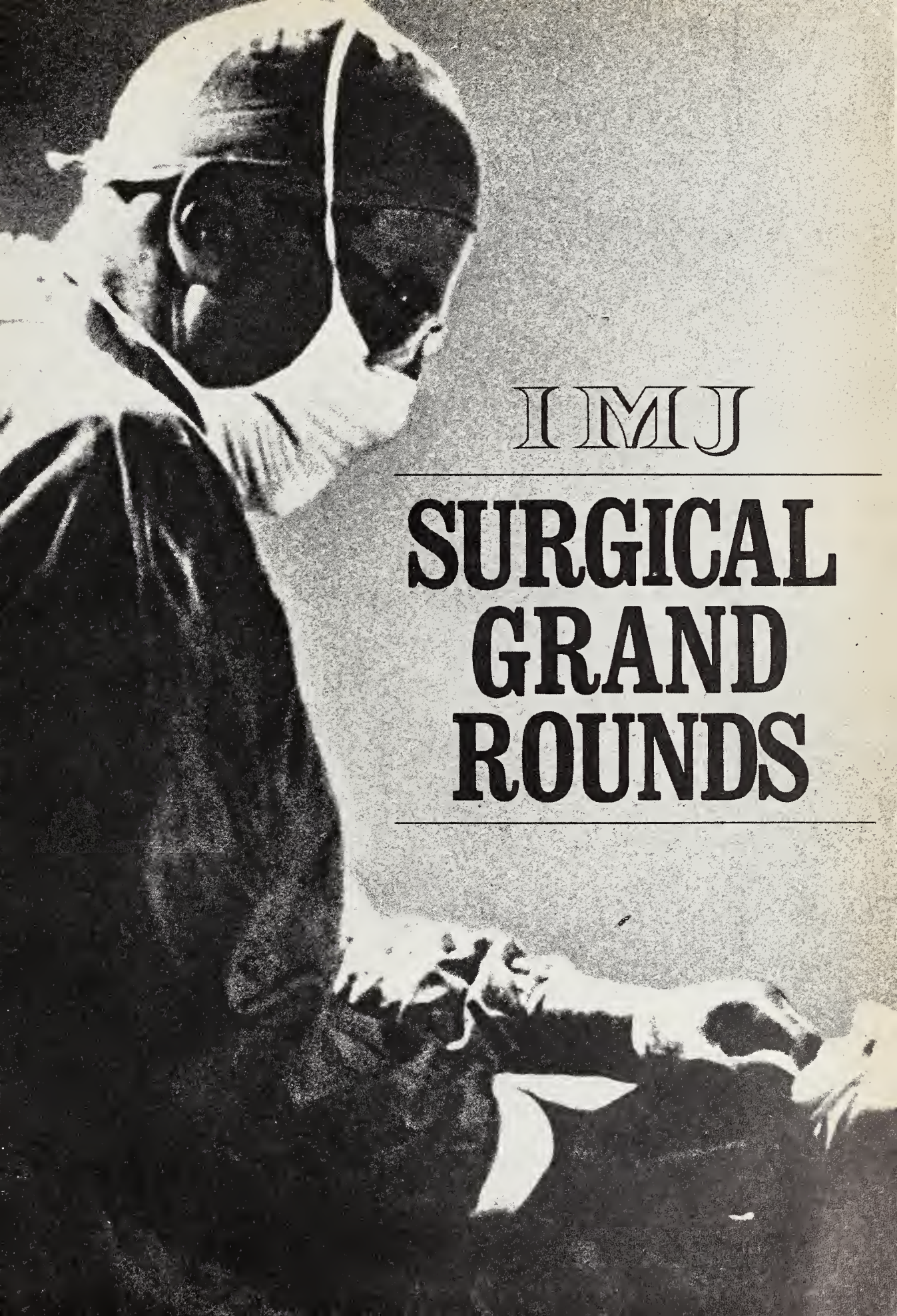
Of interest is the long term survival of this patient despite the fact that three of his four tumors were far advanced. No less surprising is his continuing vigor and stamina despite pancreatectomy and extensive excision of the gastrointestinal tract.

### References

1. Moertel, C. G., Barga, J. A., and Soule, E. H., "Multiple Gastric Cancers; Review of Literature and Study of Forty-two Cases," *Gastroenterology*, 32:1095-1103, June 1957.
2. Warren, S. and Gates, O., "Multiple Primary Malignant Tumors; A survey of the Literature and a Statistical Study," *Am. J. Cancer*, 16:1358-1414, November 1932.
3. Rae, M. V., "Multiple Malignancy," *Med. Serv. J. Canada*, 14:193-198, March 1958.
4. Watson, T. A., "Incidence of Multiple Cancers," *Cancer*, 6:365-371, March 1953.
5. Warren, S. and Ehrenreich, T., "Multiple Primary Malignant Tumors and Susceptibility to Cancer," *Cancer Res.*, 4:554-569, September 1944.

(Continued on page 204)





IMJ

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**SURGICAL  
GRAND  
ROUNDS**

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*Surgical Grand Rounds are held weekly on Saturday at 8:00 a.m.; alternating between the Staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds held at Chicago Wesley Memorial Hospital on March 1, 1969.*

## Portal

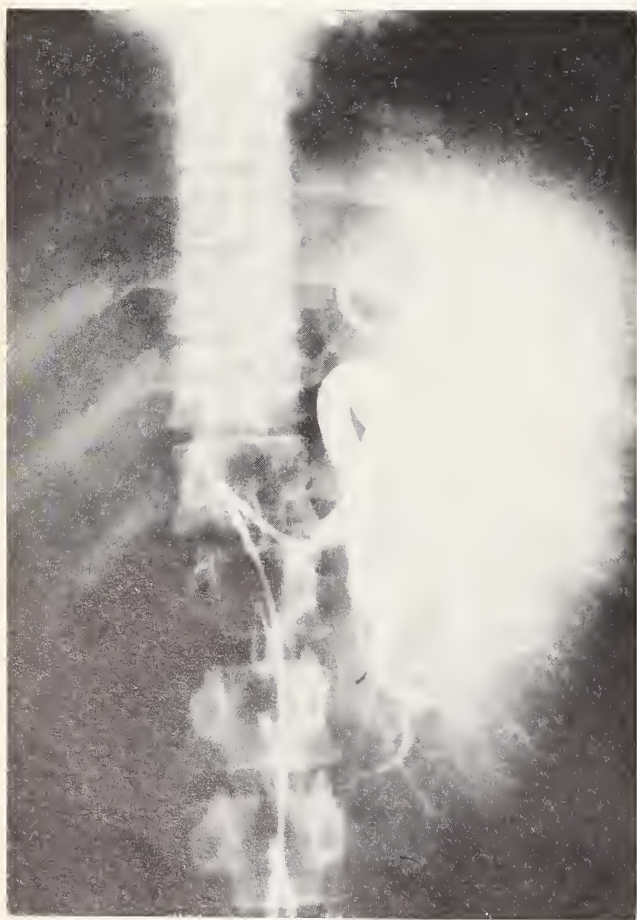
## Hypertension

EDITED BY DR. JOHN M. BEAL

### CASE REPORT:

**Dr. Edward Ghislandi:** The patient is a 28-year-old Puerto Rican male, who came to the hospital with the chief complaints of left upper quadrant pain and fullness. He contracted schistosomiasis at the age of 14 when he was in Puerto Rico and came to this country soon thereafter. In November, 1967, he had massive upper GI bleeding and was taken to another hospital where he was thought to have duodenal ulcer. An exploratory laparotomy was performed. An ulcer was not detected but he was found to have esophageal-gastric varices. Bleeding was controlled by insertion of a Sengstaken tube. A liver biopsy was obtained. He recovered after a stormy post-operative course. Since that time he has noticed intermittent full quadrant pain and fullness and on occasion he noted dark stools. At the time of admission to Wesley, he was found to have marked splenomegaly, tenderness in the left upper quadrant, and the liver was palpated at the costal margin. Urinalysis was normal. BSP was within normal limits and serum and protein levels were normal. The blood ammonia level was slightly elevated. Hematocrit and hemoglobin levels were within normal limits but his platelet count ranged between 60,000 and 90,000. A bone marrow aspirate demonstrated a hyperplastic pattern. A selective celiac angiogram was performed.

**Dr. Earl Nudelman:** There is a GI series which showed varices. Several films of the abdomen demonstrate the marked splenic enlargement. There is downward displacement of the splenic flexure of the



**Figure 1** Arteriogram demonstrates the tortuous splenic artery and greatly enlarged spleen.

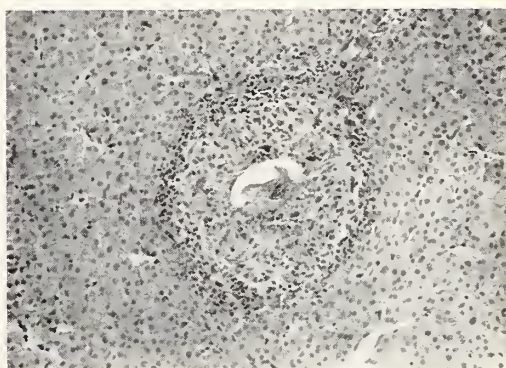


# Due To Schistosomiasis

colon and lateral displacement of small bowel loops. An angiogram was done approximately 10 minutes following injection of 40 micrograms of epinephrine to the splenic artery. This procedure allows better visualization of the portal system after arterial injection. The exact mechanism of that is not known. It may very well be a postreactive hyperanemia mechanism. The early films showed an enlarged, tortuous splenic artery (Fig. 1). The catheter is in the celiac axis and selectively in the splenic artery. The later films show a normal sized portal vein and no evidence of varices. Inferior and medial to the spleen on late films collateral vessels are seen coming from below. We got a fairly good portogram here considering it was done from the arterial side, not as good as when a splenoportogram is done, but satisfactory, I think, considering the large size of the spleen. The increased risk of splenoportogram may not give enough additional information to warrant this procedure.

**Dr. Ghislandi:** At time of operation the spleen was quite large. The portal pressure was to 27 cm of saline. A splenectomy was performed and a splenorenal shunt was performed. After the shunt, the portal pressure was 21 cm of saline.

**Dr. Kenneth Schneider:** The liver biopsy, which was obtained at the time of his original operation, demonstrates the parasite in the liver (Fig. 2). The periportal fibrosis in the liver is interrupting the lobular architecture and has resulted in cirrhosis. To begin the life cycle of *Schistosoma mansoni*, the egg hatches into a free-swimming ciliated larval form, the miracidium, which is ingested by a snail. Within the snail, it hatches into another



**Figure 2** Photomicrograph shows granuloma in the liver with a deformed *Schistosoma* ovum in the center.

larval form, the cercaria. This either is ingested by humans or burrows through the intact skin. They migrate in through the venous and lymphatic system, to the portal veins. The worm develops into the adult and the male and female coexist, the male living in the lateral groove of the female. Copulation takes place in the mesenteric and hemorrhoidal veins. The eggs gain access to the liver through the portal vein. Some of the eggs are excreted in the feces and the cycle is repeated. When one considers the diagnosis of Schistosomiasis, the fresh rectal biopsy should be pressed under a glass cover so that one can look through large amounts of the mucosa easily. The organisms can be detected readily in the rectal mucosa, and are quite easily identified.

**Dr. John Bergan:** The reason for bringing this case to your attention is to re-emphasize that in this mobile society of ours the disease Schistosomiasis occurs in patients here in Chicago, and they may re-

quire treatment for their portal hypertension. Schistosomiasis is by far the most important cause of portal hypertension in Latin American countries and, as we see here today, it presents a unique opportunity to prevent variceal hemorrhage in a patient with very good liver function.

We were faced with a unique problem in surgery which was of interest. The spleen was horribly large, but easy to take out as Dr. Lorenzo pointed out. Portal pressure at this time was 270 mm H<sub>2</sub>O. By occluding the splenic artery and vein it was possible to drop portal pressure in the portal vein itself to 180 mm H<sub>2</sub>O. At that particular moment the question arose of why not do a simple splenectomy as definitive treatment of this portal hypertension. It is hard to imagine that a shunt could produce a more effective pressure drop.

It is well known that splenectomy alone in shunt procedures is ineffective and does not cure portal hypertension. But the question then arose, what about splenectomy in Schistosomiasis portal hypertension? Does the Puerto Rican in Chicago, now no longer subject to re-infection by the parasite, undergo progression of his cirrhosis? These are questions the answers to which do not come easily at the operating table.

Schistosomiasis is an incurable condition. The cirrhosis progresses regardless of re-infection. For these reasons a standard type shunt was done. As you can recognize from presentation of the case, there were two objectives in doing such a shunt. One was to cure the hypersplenism by splenectomy. The second was to decompress the portal

system. In the usual cirrhotic, an approach to the splenic vein behind the pancreas through the retropancreatic fusion fascia is very difficult because of the portal hypertension. However, it is apparent that in the Schistosomiasis patient this is quite an easy approach. It was easy to raise the pancreas and anastomose a huge splenic vein side-to-side to the renal vein using conventional technique. Here again the drop in portal pressure was not as dramatic as was present when we clamped the splenic pedicle, but was perfectly adequate.

The question arises in treating this type of patient with hypersplenism and portal hypertension, what about a simple end-to-side porta-caval shunt? Is this effective? Rousselot in New York has the largest experience that has been published in this regard. He found that in patients with hypersplenism an end-to-side shunt produced definite improvement in one-third, no change in one-third, and progression of the hypersplenism in another one-third of his patients. In Boston, Carin has described certain physical characteristics of the spleen which might help at the operating table in deciding which should be removed. The best index is a hard, fibrotic spleen. A large spleen with hypersplenism will not shrink. If the spleen is soft, easily decompressible at the operating table, it will very likely decompress following surgery and the hypersplenism will reverse. ◀

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### Accidental Falls Kill 20,000 Annually

More than 20,000 people in the United States die annually from injuries sustained in accidental falls, according to statisticians of Metropolitan Life Insurance Company. This toll, exceeded only by that from motor vehicle accidents, represents a death rate of 10 per 100,000 population.

National Health Survey data indicates that 12 million persons each year are injured seriously enough in falls to require at least one day of restricted activity or medical attention—a record unmatched by any other type of accident. Moreover,

about 3 million persons in the United States have an impairment of the back, limb, or other part of the body, which resulted from an accidental fall.

The death rate from falls increases markedly with age, ranking fifth as a cause of accidental fatalities at ages under 25, third at ages 25-44, second at ages 45-74 and first at ages 75 and over. At the advanced ages, 75 and over, the number of persons killed in falls is 3½ times that killed in motor vehicle accidents.



# Psychological and Physiological Aspects Of Drug Treatment In Older Children

BY PHILIP G. NEY, M.D., D.P.M./VICTORIA, B.C., CANADA

*Even though psychoactive drugs seldom have a definitive specific effect, they do have a definite place in the treatment of psychiatric disturbances in older children. Those physicians who expect their children to get well only by prescribing a drug are bound to be disappointed. On the other hand, if they will treat psychiatric disturbances as they treat other medical problems, providing many types of adjunctive treatments, they can have as rewarding experiences as with any disease. To be effective, drugs must be given in the context of the child's total transactional system. In monitoring the response to a drug, the subjective reactions of the child as well as his objective responses must be taken into consideration. Two common disorders will be discussed to illustrate these two points.*

## Psychiatric Disturbances

Psychiatric disturbances arise in a total transactional system. One can think of this as a complex metabolic process. A small change in one part of the process will disrupt the whole cycle. At the same time if a change is desired in the cycle, one must consider the whole process and determine at what point and by what method it is best to intervene. For the child, the total system includes his family, his school, his environment, and his physician. Thus, the child who is designated the patient and brought to the physician may not represent the origin of the problem or the best point at which to intervene. The most effective treatment may be obtained by intervening earlier in the cycle. For example, in a situation where a depressed mother is making very little contact with her child, who only gets her attention through aggressive behavior which irritates the father for which he criticizes the mother and thereby increases her depression, although this aggressive child may be designated as the patient, if the physician looks at the total system he will see that the best point and method to medicate is to give an anti-depressant to the mother.

The physician who is accustomed to monitoring the response of his treatment through white blood counts and temperatures sometimes has difficulty in following the effects of his treatment for psychiatric disturbances where measures of



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change have not been so explicit or exact. However, there are both objective and subjective responses that he can record and use to gauge progress. The objective response may be from the drug itself or from other intervening variables. They are physiological, behavioural, and cognitive. The cognitive one is best gauged by an evaluation of the patient's mood, sensorium, insight and reports on school progress. Unfortunately, the parents are often the least reliable when it comes to an objective evaluation of their child's behaviour. However, if they are given an objective behavioural check list or frequency counting scheme where they are only required to record the presence or absence of a particular behaviour during a period of a day, they can be much more objective. Techniques are now being used to quantify children's behaviour with great reliability. Bijou,<sup>2</sup> Werry,<sup>3</sup> and others have used these methods in homes, classrooms and playgrounds to ascertain the relative effectiveness of various treatment methods and drugs. We have developed a technique using typewriters to record the presence or absence of behaviour and can get good interobserver reliability for 15 to 20 observations every 20 seconds. VanKreven<sup>4</sup> emphasizes that it is quite possible that every individual has a different biochemical pattern and for this reason it is impossible to predict the physiological response of any given individual from the group statistical data that one is usually provided with from drug research. Thus, one must carefully monitor the individual patient's response.

### **Subjective Response**

The patient may have a very different subjective response than would be objectively recorded but this subjective response may, in the long run, determine the outcome of the treatment. His subjective response arises from the meaning of the pill, i.e., his feeling about the person who gives the pill and how it is given, and also from his subjective response to the physiological changes that he feels in himself. To one patient who is dragged to see the doctor by his angry parent the pill often means "Damn it, you are going to do what I say." Thus the effects of the medication, like the push of the parent, however beneficial, will be actively resisted by the patient. One

patient may consider the warm feeling he gets from the drug as an indication that he is being properly loved and cared for. To another patient, it may mean that his masculinity is being taken away. To one patient the drug is wonderful and to another with the same objective response, it is frightening. Most young children are quite accepting but adolescents are usually more suspicious. Children are very susceptible to changes in the environment and the pill is part of the environment.

The right drug depends on: (1) what is the nature of the problem of the person presented, (2) the system in which the child is functioning, (3) his own physiology, and (4) his own psychological make up and response to the environment. The right dosage should be titrated to increase the functioning to an optimum level and decrease the symptoms to the maximum level without causing discomfort.

### **Nocturnal Enuresis**

For those cases of nocturnal enuresis that do not have organic causes such as urethral stricture,<sup>6</sup> the total transactional system of the child is complex. The child feels ashamed that he cannot control himself. He becomes depressed and this depression is often evidenced in aggressive activity directed at his parents and his peers. The parents may also have had similar problems of enuresis or self-control themselves, and therefore have difficulty in being objective. They are often either punitive, over controlling, or overly sympathetic. Mother, particularly, tends to be over controlling and unable to let the child gain control of this activity and many others on his own. Sometimes the parents' solicitous concern actually encourages the problem. At other times the child's wetting becomes an expression of his anger and frustration directed at his parents. The child frequently shows aggressive and poorly controlled behaviour at school, irritating the teacher and losing friends. The physician may have been consulted many times and in his frustration in dealing with this resistant problem has not really wanted to see the child again.

The target symptom for drug treatment is the child's deep sleep and his unawareness of a full bladder during sleep. In a controlled study Poussaint,<sup>7</sup> has demon-



strated that the Imipramine or desipramine, as I have found, is significantly effective although this has been debated. Keeler<sup>8</sup> has evidence that there is a greater RAS arousal and vigilance during sleep, although some animal studies would appear to contradict this.<sup>9</sup> In addition to this, there is an anticholinergic activity on the bladder sphincter. The desired effect is to have the child able to wake up when he feels his bladder distended and find his way to the bathroom. Usually older enuretic children urinate frequently during the day. This may be because of a small bladder but it also may be due to a history in which they have never been expected to withhold urinating. (Because of greater inconvenience in toileting, little girls are expected to hold out longer, which fact might contribute to the sex difference in enuresis.) Desipramine should be given in dosages of 25-50 mm. at night. The only side effect might be increased alertness during the day.

Besides drugs, therapy in the total system includes family psycho-therapy, behaviour conditioning and bladder control exercises. The family should be informed that the boy has a problem that he is trying to control as much as they are, and that they do not help by teasing or cajoling him. Mother should be helped to understand how and why she may be overcontrolling him. A system of conditioning in which the boy is rewarded for a certain, initially small number of dry nights and punished by making him change his own wet bed, is also useful. In addition, to help him gain a sense of mastery and to facilitate bladder control, he should be encouraged to go for longer and longer periods of time during the day without urinating, yet drinking as much water as he can. If he can start withholding his urine for three hours and end up with eight hour intervals, it is often the case that he will be completely dry by that time. In addition to this, to tone up his sphincter muscles he should practice stopping urination midstream, an exercise that father can often demonstrate and teach his son.

As in all good medical treatment there must be accurate monitoring prior to, during, and after the period of drug treatment. Monitoring prior to treatment is to estab-

lish a base line both for the subjective and objective responses. It is essential that the parents subjective reactions to their child's taking a drug should be ascertained, as often they can make a drug fail through counter suggestion, teasing or irregular giving of the medication. Once a drug has failed, both the child and the parents lose faith in the physician and it is harder to prescribe effectively again. A simple "O.K., if you say so, doctor," doesn't necessarily mean that the parents support the idea. Their own experiences with drugs may have given them a negative attitude toward them or they might be concerned that their child would become addicted. The subjective response of the child prior to receiving a drug must also be elicited. The physician must ascertain his own attitude for he is part of the system, and his attitude will influence the way the drug is given—which greatly influences the outcome.<sup>10</sup>

An objective evaluation of the base line for responses prior to giving the drug can be obtained through the physiologic measures such as an EEG, and, if there is any question of toxic side effects, various blood levels. An accurate record of the child's usual wetting pattern, how frequently and at what time he urinates during the day, should also be recorded. At this time, a check list of other aggressive or depressive behaviour should be obtained with the parent's and the school's help. The child's mood and his present scholastic achievement should be recorded. During treatment the physician should question the child as to how he feels about the drug, preferably in the child's own language, e.g. "Do you dig this stuff?" And he is gratified to hear "Yeah, man." One should find out if the child feels able to wake up more readily, and if he feels the drug should be continued. The physician should attune himself to the anxieties of the child about drugs, for instance the fear of being controlled by them, changed by them, having a response like he remembers mother having when she took drugs. The physician might ask during treatment if a child feels he is being hooked and reassure him on all points of his anxieties, attempting to point out why he might have these feelings related to his past experiences. During treatment the physician must also ascertain the objective response in respect

to the child's physiology, his cognition, and his mood as described above. He must look into these aspects with objective and subjective responses after drug treatment has been discontinued. It is wise to continue the drug treatment for some weeks after the child is completely dry.

### **Childhood Schizophrenia**

In childhood schizophrenia, the total transactional system in which the problem arises and must be treated is more complex than the previous disorder. The various names such as childhood psychoses, autism, symbiotic schizophrenia, etc. are used; but there appear to be enough features in common to call them all "schizophrenic syndrome in childhood."<sup>11</sup>

The basic syndrome consists of an apparently bright child with islets of normal or even better than normal intelligence, but retarded in almost every area, especially speech. He is one who withdraws from the world and actively resists learning. The child doesn't relate or desire to communicate. Because he doesn't attend to environmental stimuli he doesn't learn, and therefore he appears to be retarded, though perception and memory are intact. In most instances, parents will give a history of a very sensitive child, while they themselves are over anxious and have high standards. Most frequently these parents have sought in vain for a proper school or an effective treatment center. Their guilt at seeing a beautiful child going to ruin is compounded by inferences from well meaning professionals that they are the cause of it all. Thus, the total transactional system included a frightened, withdrawn child, desperately anxious and guilty parents, badgered school authorities and a frustrated physician.

The target symptom, I believe, is the child hyper-sensitivity to environmental stimuli. Because of this hyper-sensitivity, the normal sights and sounds in particular, are perceived as a cacophonous din, something that is confusing and adverse, from which the child only desires to withdraw. Catapulted into a world of harsh, intense, confusing stimuli, the child defends himself by withdrawing. He plays by himself, he covers his ears with his hands, hides in darkened closets or patterns the incoming stimuli by stereotyped behaviour.

There are no truly satisfactory drugs but there is some evidence that deanol,<sup>12</sup> a possible precursor to acetylcholine, has some beneficial effects. Our own small studies have shown that children, if they respond well, respond with an increasing attentiveness to and interaction with the environment, a greater interest in their parents as people, and less hyper-activity. The drug should be given in dosages of two or three hundred milligrams/grams. This drug was first used as an anti-depressant and seems to have a similar paradoxal quieting effect to dexedrine in hyperkinetic children. However, as an adjunct to this drug, chlorpromazine can be given at night to help the child have a good sleep, as many don't settle down until 11 p.m. or midnight.

### **Total Treatment**

Other aspects of the total treatment involve a systematic retraining of the child's behaviour through operant conditioning and psychotherapy for the parents. The training should be directed toward (1) improving the child's relationships with people and establishing a self-identity, (2) encouraging him to direct his communication, eventually learning to communicate through words, and (3) taking an interest in his environment leading to pursuing this interest through academic learning. Psychotherapy for the patient's parents which well may be conducted by a colleague should focus on their transactional system, how they communicate with each other, what were their expectations of each other and how they were disappointed.

As with the other examples, the monitoring of the response must begin before treatment and carried through until after the drug is discontinued. It is especially important in this case, where the child is unable to communicate his subjective feelings, that the physician have a good objective measure of how the child responds. The parents can be asked to provide a count of the number of such behaviours as eye contacts, clear words and spontaneous interactions that the child exhibits during a period of the day. Such measures can give clear and concise information as to how the child is responding. These can be supplemented by the physician's taking five minutes to observe the child, counting each of these three categories of behaviour



and recording them on a graph. This graph provides a week to week profile of the child's response to treatment, much like a temperature chart. The physician may find, for instance, that when the child has a slight virus infection there is a marked drop in the response of these three categories. The graph may also show an improvement while the father is away on a business trip. This information is invaluable in treating the child in the total system.

### Conclusion

We can not expect one chemical in a vast system of inter-reactions to have a specific, definitive effect. However, if that chemical is used at the right time and at the right place in the whole system, while other aspects of treatment are also brought to bear, a physician can expect to have as great and as rewarding experiences with psychiatric disturbances as he has with other kinds of medical problems. It should be emphasized that he must monitor the psychological and physiological effects, and the subjective and objective responses as precisely as he can. ◀

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## OBITUARIES

**\*Dr. Joseph A. Davis**, Winnetka, died June 21 at the age of 54. He was former chairman of Presbyterian-St. Luke's house staff committee and past president of the Bishop Anderson Foundation.

**\*Dr. Gordon W. Elrick**, Chicago, died May 16 at the age of 70. He was past president of Bethany Methodist hospital medical staff.

**\*Dr. Ben E. Fillis**, Evanston, died June 21 at the age of 79. He was past president of the Chicago Urological Society and a member of the ISMS Fifty-Year Club.

**\*Dr. Preston S. Houk**, Bloomington, died May 29, age 48. He was past secretary of McClean County Medical Society.

**\*Dr. John Hrabik**, Murphysboro, died May 26 at the age of 82. He was past president of the Jackson County Medical Society and a member of the ISMS Fifty-Year Club.

**\*Dr. Horry Jones**, River Forest, died June 20 in Sarasota, Fla., where he retired. He was 83 years of age.

**\*Dr. Walter C. Moriarty**, Palatine, died

Feb. 24 at the age of 70.

**\*Dr. William F. Parrilli**, Chicago, died May 14, in Naples, Italy, at the age of 61.

**\*Dr. John Van Prohaska**, Chicago, died June 12 at the age of 64. He was secretary and president-elect of the Society for Surgery of the Alimentary Tract. He was a distinguished cancer surgeon.

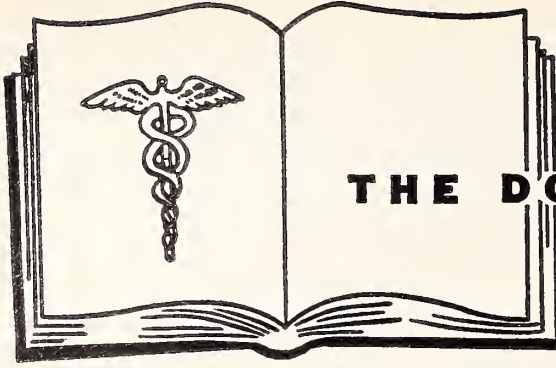
**\*Dr. Leon E. Robinson**, Aledo, died June 10 at the age of 72. He was currently serving as president and was past secretary of the Mercer County Medical Society.

**\*Dr. Irving H. Rosenthal**, Chicago, died June 3 at the age of 58. He was on the staff of Mount Sinai hospital.

**\*Dr. Herbert E. Schoonover**, Salem, died Feb. 20 at the age of 77. He was past president of the Marion County Medical Society and a member of the ISMS Fifty-Year Club.

**Dr. Louis Schwartz**, Broadview, died Jan. 31 at the age of 65. He was on the faculty of the Stritch School of Medicine, Loyola University.

\*Indicates Member of Illinois State Medical Society.



## THE DOCTOR'S LIBRARY

**RESPIRATORY CARE.** By H. H. Bendixen, L. D. Egbert, J. Hedley-Whyte, M. B. Laver, and H. Pontoppidan. Foreward by John H. Knowles, M.D., 252 Pages, Illus. St. Louis, The C. V. Mosby Co., 1965.

Dr. Bendixen and his colleagues, in the book **RESPIRATORY CARE**, have made it their aim to show how to improve patient care by the application of the principles of respiratory physiology. This part is done well, as would be expected since the authors have themselves made some notable advances.

Respiratory care, however, depends on more than this. The authors have not dealt with such matters as the architectural design of respiratory units, particularly in relation to the spread of infection, and they do not enlarge upon staffing considerations, all of which have a bearing upon patient care. Considering the importance of mechanical ventilation it is surprising to find how little space is devoted to this aspect, and there is little emphasis on how to maintain nutrition in patients on mechanical ventilation. The section on chest physiotherapy needs revision.

Apart from these matters, there is a great deal of value in this work which includes sections on (1) physiological considerations, (2) the prevention of respiratory complications, (3) therapy, which includes oxygen therapy, emergency resuscitation, and the management of patients on prolonged mechanical ventilation, and (4) an interesting account of the problems peculiar to patients with respiratory failure from various causes. One feature is the concise way in which the authors have set out their material. The work is profusely illustrated, and there is a good bibliography. Anyone interested in intensive care should have this book.

Richard P. Harbord, M.D.

**RECONSTRUCTIVE ANATOMY.** By Maurice Arnold, M.B., Ch.B. (Witwatersrand), F.R.C.S. (Edinburgh) W. B. Saunders Company, Philadelphia, London, Toronto, 1968. 529 Pages; Illus.; \$10.75.

This new anatomical text presents human anatomy with a reconstruction technique. This technique involves presenting first the skeletal background of a given anatomical region and then building the more superficial structures from this base. This provides excellent visualization of relationships between anatomical structures of different systems at any given depth. The book is well illustrated and the text concisely written.

A most original contribution of the author is a compilation of "Principles of Anatomy" as an addendum. The author refers the reader to this set of principles at appropriate intervals. The principles outlined emphasize the dynamics of anatomy. As an example under "Blood and Lymph Vessels" Principle #10: "In the forearm, the relative arrangements and roles of the two terminal branches of the brachial artery are the reverse of those in the palm. In the forearm, the ulnar artery is larger and deeper and supplies most of the ventral and all of the dorsal musculature, while the radial artery is superficial. In the palm the radial artery is larger and deeper and supplies most of the deep musculature, as well as the dorsum of the hand and the thumb and index finger.; the ulnar is mainly superficial." There are some 40 pages of such summarizing principles which reflect the author's profound understanding of his subject.

The book would seem to have its greatest appeal to medical students who now spend only a fraction of the time in gross anatomy that was previously invested. The book is designed to help the student with



a scanty dissectional experience to recall visually this past experience. The book is not designed for surgeons. The extensive use of diagrams, charts, and the aforementioned section on anatomical principles should make this book popular with medical students who have so little time for gross anatomy.

Paul H. O'Brien, M.D.

ATLAS OF FLUORESCENCE FUNDUS ANGIOGRAPHY. By Shinichi Shikano, M.D. and Koichi Shimizu, M.D. W. B. Saunders Company, Philadelphia, 1968.

Certain compounds have the property of absorbing light of one wavelength and, as a result of this energy input, emitting light of a different wavelength. This phenomenon is called fluorescence and one of the most actively fluorescing substances is an organic compound called, appropriately, fluorescein. It has been used in medicine for many years and for a variety of purposes, all based on the fact that it fluoresces at the pH of tissue. For example, applied topically it will stain corneal abrasions; given intravenously it will differentiate normal and injured vessels since the latter are permeable to the rather large fluorescein molecule while normal vessels are not.

In the eye a slightly different situation obtains. The vessel walls in the fundus are transparent and even normal vessels will fluoresce. This observation has been known for some time and allowed some studies to be made on retinal circulation. However, it was not until 1961, when Novotny and Alvis devised a method of photographing the retina at split-second intervals after intravenous fluorescein administration,

that the enormous amount of information available from fluorescein angiography became evident. Their technique, with some modifications, has now practically developed into a subspecialty of ophthalmology.

The enormous value of this tool is well illustrated by the book here reviewed. After a brief review of the principles and techniques of fluorescein angiography, the authors describe the normal fundus picture. They then proceed to pathologic states and, as might be expected, devote about half the remaining text to vascular disorders of the retina.

One might single out diabetic retinopathy as a particularly good example of the usefulness of this technique. They illustrate beautifully that there are many more microaneurysms demonstrable by fluorescein angiography than can be seen by ordinary ophthalmoscopic examination. Indeed, any so-called cure of diabetic retinopathy is suspect unless it is documented by fluorescein angiography. Perhaps the second most useful application of this technique is for the demarcation of vascular anomalies of the retina such as angiomas and "leaking" vessels. Here fluorescein is not only a diagnostic tool but also a guide to therapy since it indicates the precise areas where photocoagulation or cryocoagulation should be done.

This atlas illustrates these and many other entities. It is the first definitive text on fundus angiography and should be in the hands of all ophthalmologists. Others interested in vascular disease, and particularly in cerebro-vascular disease will find this a most interesting and useful text. It is highly recommended.

David Shoch, M.D.

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### ***Immunization Pamphlet***

"Immunization, a Priceless Health Asset," a revised American Medical Association pamphlet, reminds the public that some infectious diseases can be prevented—by immunization.

After defining active and passive immunity, the folder accents preventable diseases and stresses the type of immunity available for each one.

In addition, the pamphlet contains an immunization schedule which serves as a flexible guide and reminder for obtaining initial immunization, booster shots and adult immunization.

Copies may be obtained from the AMA Order Handling Unit at 10¢ each; 9¢ each in lots of 50-99; 8¢ each in lots of 100-499; 6¢ each in lots of 500-999; and 4¢ each in lots of 1,000 or more.

# Current Physical Examination And Immunization Procedures

BY MARY ZELDES, M.D., F.A.A.P./DECATUR; DONALDSON F. RAWLINGS, M.D., M.P.H.,  
AND HARRY BOSTICK, M.S.ED., M.P.H./SPRINGFIELD

*The program to ensure the optimal health of every school aged child in Illinois has had a long, slow birth and development. The Illinois Constitution of 1870 stated that "The General Assembly shall provide a thorough and efficient system of free schools whereby all children of this state may receive a good common school education." Approximately 90 years passed before recognition of the relationship between good health and the ability to learn was enacted into legislation. On March 18, 1961, the General Assembly approved "An Act in relation to the establishment, operation, and maintenance of public schools . . ." Article I, Section 1-1, stated, "This Act shall be known and may be cited as 'The School Code.'" It was at that time, under Article 27, Section 27-8, that "Physical Examinations of School Children" became an integral part of the School Code. The Illinois Department of Public Health was officially designated to prescribe rules, regulations, and procedures for the physical examination and its content.*

*Many changes have taken place since the 1961 approval of the School Code. Dramatic advances have occurred in the educational process itself, and this has been accompanied by a rapid expansion of knowledge in the field of medicine—preventive, diagnostic and therapeutic. There has been an increased awareness of the interrelationship of emotional, social, and physical health. The care of children has become more complex, and the delivery of this care efficiently to all children poses, as yet, many unsolved problems.*

## School Health Program

The term, "School Health Program," is an artificial designation, so labelled only because many of its activities are school-centered. School children are a captive audience, so to speak, because by law these children must be within the four walls of their schools for a prescribed number of hours of a prescribed number of days; they can be counted and accounted for, appraised, diagnosed, referred, disciplined, and even computerized for statistical purposes. They are accounted for even when absent from school, and their absences may be as revealing from a standpoint of education and health as their presence at school. And yet, as every educator and every physician knows, the health program of the school aged child neither starts nor stops with the beginning and completion of school attendance. Ideally, the health of the school aged child starts before birth and continues after the school years have ended.

It is axiomatic that the ability to learn is in direct relationship to the degree of physical and mental health of the child. The responsibility of ensuring the child's optimal health is a shared responsibility; it rests primarily with the parents and their family physicians and dentists, but often needs to be supplemented by official agencies such as the Department of Public Health and the Office of Public Instruction as well as the schools, local health departments, and voluntary agencies in the community. It has always been the intent of Section 27-8 of The School Code that physical examinations of school children should



be the individual family's responsibility, if at all possible.

### The School Code

Since March 18, 1961, the General Assembly, with the approval and signature of the Governor, has passed several amendments to improve or to make additions to Section 27-8 of The School Code. Originally, the required physical examinations of school children applied to those entering kindergarten or first grade, fifth, and ninth grades in "public schools" only. This was later amended to read in "public, private, and parochial schools." In 1963, an amendment was enacted pertaining to the refusal of physical examinations on constitutional grounds. Later amendments approved licensed optometrists for visual examinations and licensed podiatrists for foot examinations, in addition to the previously designated physicians licensed in Illinois to practice medicine in all of its branches.

In 1967, "An Act in relation to the prevention of certain Communicable Diseases" was approved by the Illinois Legislature. Essentially, this act required mandatory immunization against pertussis, diphtheria, tetanus, smallpox, poliomyelitis, and measles. Booster immunization procedures

were to be carried out in accordance with the requirements designated by the Illinois Department of Public Health aided by the advice of its statutory Advisory Committee. The mandatory immunization requirements were incorporated as an Amendment to Section 27-8 of "The School Code."

During an emergency session of the Legislature in August, 1968, three important measures were adopted in relation to Section 27-8 of "The School Code":

- 1) All previous amendments were incorporated into one *new* Section 27-8 of The School Code.
- 2) The amendment stated that not later than September 1, 1969, results of school physical examinations must be recorded on forms approved by the Department of Public Health.
- 3) Evidence of malnutrition was to be recorded as a separate entity in space provided on the form for the examining physician to indicate such evidence. Furthermore, if evidence of malnutrition was reported, a duplicate copy of the form was required to be sent to the Department of Public Health by the appropriate school authorities.

The current revised Section 27-8 of "The School Code" as amended August 16, 1968, is herewith reproduced in its entirety:

**AN ACT** to amend Section 27-8 of "The School Code," approved March 18, 1961, as amended.

*Be it enacted by the People of the State of Illinois, represented in the General Assembly:*

**Section 1.** Section 27-8 of "The School Code," approved March 18, 1961, as amended, is amended to read as follows:

**Sec. 27-8.** Physical examinations. Physical examinations as prescribed by the Department of Public Health, shall be required of all pupils in the public, private and parochial elementary and secondary schools, except as hereinafter provided, immediately prior to or upon their entrance into kindergarten or the first grade, and upon entrance into the fifth and ninth grades and, irrespective of grade, immediately prior to or upon entrance into any public, private or parochial school in Illinois. Additional health examinations of pupils may be required when deemed necessary by the school authorities. In addition to the



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physical examination, every child prior to or upon entering kindergarten or first grade and every pupil first entering any public, private or parochial school in this State, except as hereinafter provided, shall be immunized against measles, smallpox, tetanus, diphtheria, poliomyelitis and pertussis. The Department of Public Health may require immunization or booster immunization against any one or more of these diseases for pupils entering the fifth and ninth grades.

The examinations shall be made by persons licensed to practice in Illinois who are employed for that purpose by the parents or guardians of the children examined: physicians licensed to practice medicine in all of its branches for physical examinations, licensed dentists for dental examinations, physicians licensed to practice medicine in all of its branches or licensed podiatrists for foot examinations, and physicians licensed to practice medicine in all of its branches or licensed optometrists for vision examinations. Commencing not later than September 1, 1969, results of such examinations shall be indicated on forms approved by the Department of Public Health, which forms shall include, in addition to all other relevant data, space for the examining physician to indicate any evidence of malnutrition found in the pupil examined. The Department of Public Health through designated agencies may accomplish such examinations of those children who cannot otherwise be examined. In cases where any examination pursuant to this Section indicates evidence of malnutrition, a duplicate copy of the form indicating the results of such examination shall be sent to the Department of Public Health by the appropriate school authorities. Cumulative records of the examinations shall be kept by the school authorities.

Pupils objecting to physical examinations or immunizations on constitutional grounds shall not be required to submit themselves thereto if they present to the school boards or Board of Governors of State Colleges and Universities a statement of such objection signed by a parent or guardian of the child. If the physical condition of the pupil is such that any one or more of the immunizing agents should not be

administered, the examining physician shall endorse such fact upon the physical examination form. Exempting a pupil from the physical examination does not exempt him from participation in the program of physical education and training provided in Sections 27-5 through 27-9.

The Illinois Department of Public Health, charged with establishing rules, regulations, procedures, and content of the physical examination, realized the magnitude and the difficulties inherent in such an undertaking. Among the many problems was recognition of the fact that many physicians have their own ideas as to what constitutes an adequate physical examination, and also that most physicians are so burdened with "paper work" that they are reluctant to fill out still another lengthy detailed form. Furthermore, there remains the overwhelming problem of keeping any physical examination form up to date. The rapid accumulation of medical knowledge and concomitant legislation often leads to changes before the basic rules and regulations can be promulgated. For example, measles immunization and evidence of malnutrition were both made statutory requirements while the work on the initial form was in progress. Undoubtedly, rubella and mumps vaccination and many as yet undiscovered health measures may require changes in the examination form in the not too distant future.

With the above factors in mind and cognizant of the difficulties ahead, the Illinois Department of Public Health was still under mandate to establish rules, regulations and content of the physical examination. A school health form was eventually devised, including the following components: (1) Suggested procedures for use of forms; (2) Dental Examination; (3) Medical History; (4) Significant Developmental History (at the discretion of the examining physician); (5) Immunization Record; and (6) Physical Examination. The proposed form was discussed by the Department staff, revised and polished, and sent to various interested agencies in Illinois for comments and suggestions. The final form was approved by the Illinois State Medical Society, the Illinois State Dental Society, the Illinois Office of the Superintendent of Public Instruction, the Illinois Department of Public Health, the Illinois



**Table 1**

**SCHOOL HEALTH EXAMINATION - ILLINOIS**

County \_\_\_\_\_ School \_\_\_\_\_ District \_\_\_\_\_

Pupil's Name \_\_\_\_\_ Sex \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_ Birthdate \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_ Phone \_\_\_\_\_

**PHYSICAL EXAMINATION**

	FINDINGS
Height	
Weight	
Blood Pressure	
Eyes - Abnormalities noted	
Visual Acuity	
Test Used	
Ears - Abnormalities noted	
Hearing Acuity	
Test Used	
Nutrition - See Note Below *	
Skin	
Scalp	
Posture	
Orthopedic	
Feet	
Nose	
Throat	
Glands	
Thyroid	
Heart	
Lungs	
Abdomen	
Hernia	
Nervous System	
Speech Defect	
Urinalysis	
Blood Ct. or Hgb (if indicated)	
Other (Specify)	

Significant findings with recommendations to include: referrals, screening for vision, screening for hearing and speech, etc. Also, please indicate any long-term medication being given and state reasons.

The above-named person is physically able to participate in physical education and competitive sports unless otherwise specified.

If either vision or foot examination is given by other than the reporting physician, the name of the examiner should be given here:

Name \_\_\_\_\_ Degree \_\_\_\_\_

Name \_\_\_\_\_ Degree \_\_\_\_\_

\* Illinois law requires cases of evidence of malnutrition to be reported to the Illinois Department of Public Health by school administrator. Check box if evidence of malnutrition is present ☐

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Health Officer's Association, and the Illinois Congress of Parents and Teachers.

The approved physical examination form is to be sent to every school administrator in Illinois as a sample or model to be used in his school. The printing and distribution of the forms in each school is the school district's responsibility. The school may use an exact copy of the sample or may modify it to its own specifications, providing it includes *no less* information than the sample depicts. After September 1, 1969, all physical examination forms must be sent to the Illinois Department of Public Health, Room 500 State Office Building, Springfield, 62706, for approval.

The Physical Examination portion of the School Health Form (see Table I), needs a few explanatory remarks. The Department felt that a definite distinction should be made between eyes and vision, and between ears and hearing. This does not mean that every examining physician is required to do a visual acuity and/or an audiometric test. It does mean, that if an examiner marks "eyes—normal," he is referring to gross or visible eye conditions, such as conjunctivitis, styes, strabismus, etc. Under visual acuity, he may record the findings of a Snellen Chart examination (20/20, etc.) or he may record "not done," or he may record "done by a technician, see technician's report." The same type of procedure holds for ears and hearing acuity. In the future, if any school chart is examined in retrospect, the report "eyes—normal" and "ears—normal" on the record, will in no way reflect the status of the child's vision and hearing acuity.

The subject of malnutrition in this country has become quite vocal in the past year. No one really knows how much evidence of malnutrition exists in Illinois. The emergency legislation of August, 1968, reflected the interest of the legislators in determining the extent of malnutrition in our state. Since malnutrition *per se* is a nebulous term, the form asks for *evidence* of malnutrition as interpreted by the examining physician. This evidence may appear as marasmus, extreme weight loss, obesity masking edema, dermatitis, or varied other physical findings. Whenever evidence of malnutrition is recorded by the physician, the school administrator must send a copy of the form to the Illinois Department of Public Health who in turn will keep a record of the number of cases and instigate an investigation.

The remainder of the Physical Examination form is self-explanatory. The Department of Public Health does not claim that this is the perfect or ideal form, but it is a consensus form requiring information basic to a good complete physical examination and has been approved as such by many interested authorities and agencies.

Pursuant to the legislation making immunization mandatory for diphtheria, tetanus, pertussis, smallpox, polio, measles, and other communicable diseases which are or which may in the future become presentable by immunization, the Department of Public Health with the aid of a statutory Immunization Advisory Committee devised and on January 23, 1968, officially promulgated rules and regulations concerning immunization. ◀

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**A NEW HOT LINE.** The next time you get upset over what's going on in Washington or your state capital, you can get it off your chest quickly with a new Western Union service called the Personal Opinion Message. For 90 cents, Western Union will send a 15-word telegram to the office of your President, Governor, Congressman, Senator or State Legislator—and they'll throw in your signature and address free. You don't even need to know your representative's name. Western Union will look

it up for you. To send a POM, you need only pick up the telephone. The 90 cents will be added to your phone bill. Health Bulletin sees the POM service as a boon to the beleaguered taxpayer who objects to government action—or nonaction—concerning his health and welfare but who doesn't have the time to sit down and compose a letter or make lengthy phone calls to make his voice heard. (*Conservation News*, April 15, 1969)





HARVEY KRAVITZ, M.D.  
Medical Progress Editor

## Reactions

To

## Drugs

BY MAX SAMTER, M.D./CHICAGO

When I accepted an invitation to present a relaxed and informal appraisal of the fundamental and practical problems of reactions to drugs, on the eve of my departure to South America, I underestimated the difficulty of the assignment. Ever since the Kefauver hearings, drugs have been a subject of passionate debate and controversy. Only a few decades ago, "reactions to drugs" could be considered a suitable subject for detached scientific inquiry and analysis. Witness the change: a recent symposium on "Drug Responses in Man" dedicates its printed proceedings to the hope that they "will contribute to a wider understanding, both by scientists and the public, of the problems—arising from individual, genetic, sex, species, statistical, metabolic, or even emotional differences—involved in the production of new drugs." As if this were not enough, one wonders why the economic and social factors which complicate the process of design and distribution of new drugs have not also been given recognition.

One might reason that our ability to synthesize new drugs at will is only a minor

by-product of our technological revolution. Minor, if measured against the impact of unlimited power which we have created by atomic fission and fusion. Minor, I suspect, compared with the conquest of outer space. Yet, astronauts who circle the moon are part of our age, but not necessarily part of our lives. Our concern with drugs is far more personal and intimate. The safety of drugs is a major issue because drugs, like pollution of air and water, affect us all.

It has been said that technological advances seem to come our way far ahead of our ability to cope with them. Medicine has its share of technological problems. Oral contraceptives do not only prevent unwanted children, but force us to come face-to-face with an entirely new code of standards and behavior. Transplantation of organs is not only a question of skills, but a question of ethics as well. The increasing longevity of people has made it necessary to cope with the role of the aging in our competitive society, and to reassess the meaning of death. Screening of patients with near-infallible analyzers will improve our diagnoses, but might play havoc with old-fashioned physician-patient relationships. The speed with which new drugs are introduced into medicine has created an urgent need for predictive tests which will prevent disasters as enormous and as unpredictable as the disaster caused by thalidomide.

Should we be surprised then that the current issue of the "Bulletin of the Atomic Scientist" devotes close to seven pages to the question: 'Drug Testing—is time run-



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the University of Pennsylvania before coming to Chicago.

ning out?' The essay recognizes our gains in the conquest of disease but asserts that the prevention of therapeutic catastrophes is the responsibility of the profession: "We must all face the unpleasant fact that adverse reactions to drugs are major public problems."<sup>1</sup>

### The Scope of the Problem

The problem of drug reactions is a problem of staggering dimensions. In the Dartmouth Convocation on "The Great Issues of Conscience in Modern Medicine," Warren Weaver created the expressive term 'statistical morality' for our pharmacological predicament. He pointed out that at the turn of the century a drug which would produce a single fatality in one million patients per year could be called a "safe" drug. Today such a drug is no longer safe: improved communications have made it possible to distribute new drugs within months to every corner of the globe, in other words, to over three billion people. The safe drug, which—given to one million people—causes fatal reactions in a single patient, is bound to kill up to three thousand people each year: this might be justified for a drug which is used for the treatment of a high-risk disease, but surely is not justified for drugs which, like tranquilizers, are prescribed electively, and often for minor illness.

Other statistics: of 251 new drugs introduced between 1958 and 1964, eight produced serious reactions and had to be withdrawn from general distribution. Of these eight, two might have been expected to produce untoward side effects on the basis of existing pharmacological evidence, but six produced unexpected agranulocytosis and hepatitis in man.<sup>2</sup>

It is the responsibility of the Food and Drug Administration to supervise the safety and effectiveness of new drugs. You are familiar, of course, with the tug of war which is a matter of public record: it is not easy to reconcile a drive for more effective drugs with the commitment to protect—*primum non nocere*—our own patients. The Food and Drug Administration has accepted the logical charge to make facts about new drugs known to physicians: this has not been convincingly successful. Physicians—like faculties and students of medi-

cal colleges—suffer from an over-abundance of available information, not from the lack of it. And they assign priorities in self-defense. In a recent post-graduate seminar on psychopharmacology which I happened to attend, a speaker said "Valium with which you are, of course, familiar . . . ." I asked the speaker to estimate the degree of familiarity; curious, he conducted an informal inquiry during the intermission. Of 48 participants, only six knew the generic name of the drug, none even its approximate chemical structure. In subsequent talks, the speaker wondered whether physicians ought to be familiar with chemistry and biotransformation of drugs. The answer was a resounding 'No'! It was unrealistic, they said, to expect a working knowledge of chemistry, years after graduation. They expressed interest in the metabolic fate of drugs; and doubts whether such information—were it accessible to them—would change their habits of prescribing. As one of the discussants summed it up: "By and large, we are prescribing on faith."

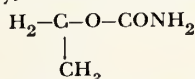
True, but faith in what? The dialogue which began with the hearings initiated by the late Sen. Kefauver seems to continue: most of us are innocent bystanders, but we might get hurt. Progress has been made in defining the issues, and the protagonists appear to be on speaking terms. It would be quite proper, I believe, to dedicate this survey jointly to the Food and Drug Administration and to the pharmaceutical manufacturers: there are saints and sinners on either side.

### Nature of Drugs

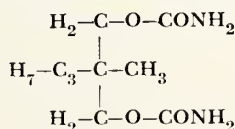
It might be helpful to re-state some facts which might make it easier to accept the overwhelming number of new drugs with equanimity. Many drugs are not really "new"; and the classification of new drugs is not any more difficult than it used to be. Drugs known as teas made of leaves, flowers, or roots of plants have been isolated and identified; and "molecular manipulation" of their components has transformed the parent compound into something new which is more effective and, it is hoped, less toxic. Old drugs compete with new drugs although it seems that drugs which our grandfathers prescribed—while still available—now lead an almost



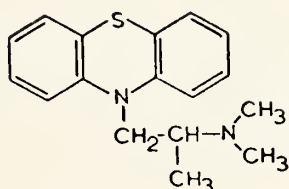
subversive existence. It is not always easy to recognize the relationship between an "old drug" and a newly synthesized derivative: the pharmaceutical industry as a whole—so magnificent in the development of new drugs, so concerned on the other hand with efforts to secure a place in the sun for them—prefers to stress the 'newness' rather than the relation to the past. It is an instructive exercise to trace the ancestry of drugs. Everyone who has been exposed to elementary chemistry, remembers urethane:



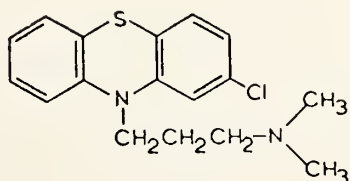
but urethane has been overshadowed by the fame and affluence of its offspring\*:



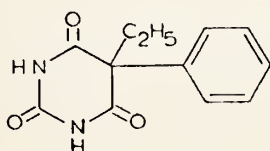
Promethazine is an effective antihistamine, and has been with us for years:



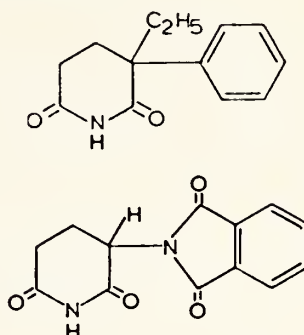
but its derivatives have changed our world—*e.g.* this compound which resembles promethazine closely\*\*: only a halogen has been added in the nucleus, and the N atoms on the side chain are separated by three carbons, instead of two:



Phenobarbital is a classic sedative:



but its "non-barbiturate" descendants† now get equal attention:



It is not possible to limit the term "drugs" to prescriptions: chemicals to which we are exposed must be considered and counted not necessarily because they represent a hazard as such, but because they might interfere with the expected handling of drugs which we prescribe. Food additives, food preservatives, insect sprays, a multitude of solvents or detergents often sold under innocent labels, have become part of our technologically conditioned environment. We tend to accept the benefits which we gain from the increasing use of chemicals—*e.g.* the sanitation of our water supply or the increase in our harvests by effective attack on pests—without question: we seem to be greatly astonished, on the other hand, when we read about adverse effects—"a silent spring"—which we might well have expected.

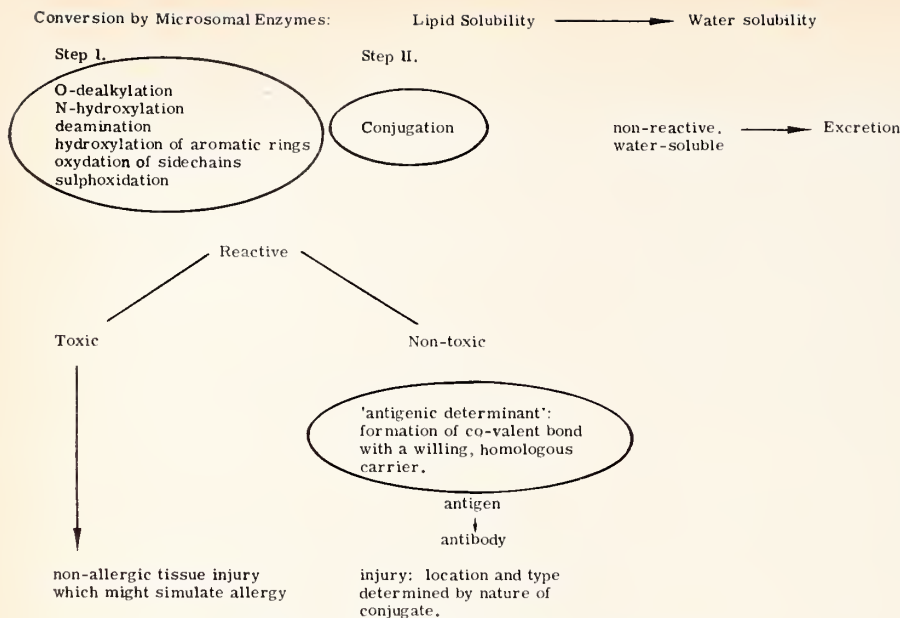
### The "Normal" Handling of Drugs

Drugs are taken, absorbed, transported by plasma, and excreted: this sequence occurs without particular attention to the reason for which the drug has been given. Somewhere during this sequence, the drug tends to become inactive although even excreted metabolites might retain pharmacological activity. Several pathways of excretion exist—drugs can be excreted through skin and nails, lungs, bile and stools—but the excretion via the kidney has been most widely studied and clarified. Excretion by the kidney requires water-soluble drugs. "Polarization," therefore, is the ultimate goal of the metabolic handling of a drug. It is not necessary, of course, to metabolize drugs which are already polar:

\* meprobamate

\*\* chlorpromazine

† glutethimide and thalidomide



**Fig. I. General Outline of the Biotransformation of Drugs.**

Step I may be either a preparatory or a final step.

Step II adds a polar conjugate.

arsanilic acid, for instance, or methotrexate can be excreted without metabolic transformation, but polar drugs are in the minority. Non-polar drugs are usually metabolized in two steps which are outlined in Fig. I. Step one: oxidizes, reduces, or hydrolyzes the drug; this tends to make the drug more polar, but, as a rule, not polar enough. Step two: conjugates the product of Step one, suitably altered, with a highly polarized compound, *e.g.* with hippuric acid or with the ubiquitous glucuronide. In principle, then, drugs can be excreted in three forms—(1) unchanged; (2) as Step one—metabolites, *e.g.* after oxidation or reduction; and (3) as Step two—metabolites formed after conjugation of a Step one—metabolite with a suitable polar compound. Occasionally, non-polar compounds like ether or halothane are excreted without metabolic transformation, but no one seems to be entirely certain why. Exceptions, of course, are important because they emphasize the limits of predictability.

Metabolic transformation is a function of microsomal enzymes. The discretion of the microsomes is truly amazing: they are able to distinguish between complex endogenous compounds which “belong,” and simple chemicals which do not. It has been said that, during evolution, the microsomes have “learned” to handle endogenous compounds or the components of food which we need: much of it is fruitful speculation. It is pleasant to think that when

new drugs are given, the microsomes experiment with various forms of biotransformation and select, preferentially, the most promising pathway toward polarization.

In the past, metabolic handling of drugs has been equated with “detoxication”: this is not correct because a metabolite might be more water-soluble but might acquire different pharmacological properties—

like phenylbutazone which is metabolized into either an anti-inflammatory or a uricolytic compound—and might become more toxic than before.

Fortunately the majority of drugs will behave according to expectations, and be assigned, for processing, to one of the three categories which have been described: it is obvious, of course, that this is a didactic simplification. Biologically—but not necessarily from the standpoint of the pharmaceutical manufacturer or of the physician who might prefer a long-acting to a rapidly excreted drug—the most desirable category produces metabolites which are polarized, non-toxic, and readily excreted. Fig. II illustrates how the rat handles amphetamine: hydroxylation followed by conjugation to glucuronide. Fig. III presents the transformation of an analgesic (now obsolete) which is transformed into a toxic hydroxylamine and causes methemoglobinemia. Finally, Fig. IV shows the example of a metabolite (of penicillin) which is non-toxic *per se*, but has acquired, during Step one processing, the ability to form covalent bonds with homologous protein. It has become a “hapten” (Landsteiner’s term) or—as it is now called—an “antigenic determinant.” A hapten forms a stable non-ionic attachment with a macro-molecular carrier: the conjugate is a complete antigen which can induce sensitization in experimental animals and man.



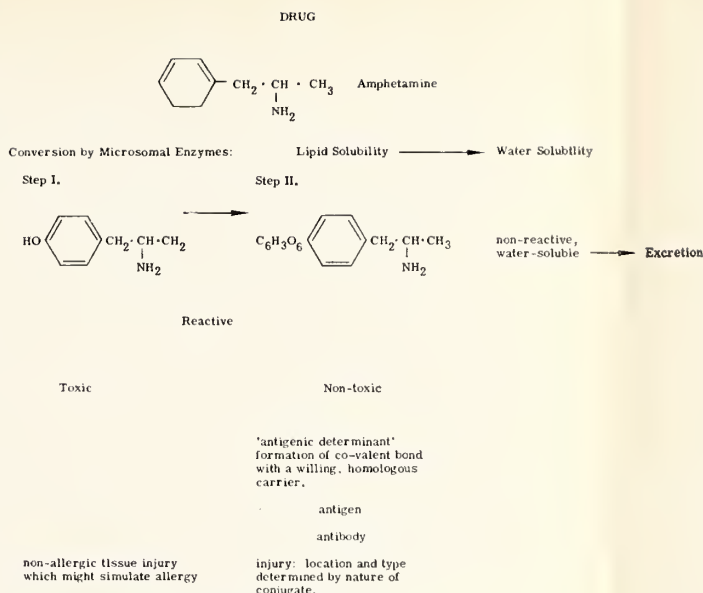
## A Diversion: Hypersensitivity To Drugs

The condition *sine qua non* for the development of hypersensitivity to drugs in man is the formation of a conjugate between a hapten and a homologous component of tissue. It is comparatively easy to sensitize experimental animals with haptens which have been conjugated in vitro with a suitable molecular carrier, but man is a peculiar animal: it almost appears as if he were unwilling to form, under normal circumstances, antigenic conjugates. Infection, however, encourages the formation of conjugates probably by making amino acid residues more readily available: there is general agreement that infections increase the incidence of drug reactions.

Even after a conjugate has formed, sensitization is not obligatory. Early investigators assumed that the type of sensitization might depend on the nature of the endogenous component; that conjugates of haptens with protein might induce allergies of the "immediate" type, while conjugation of haptens with lipoids, *e.g.* with the wax-fraction D of the tubercle bacillus, might produce "delayed" inflammatory reaction. Unfortunately, a significant number of exceptions to this attractive concept make it no longer possible to generalize about the role of the macromolecular carrier.

The statement that the antigenic conjugate is a prerequisite for sensitization does not necessarily mean that the antigenic conjugate *must* initiate an immunological sequence in every species or even in every individual within the species: to a certain extent, genetic factors control the response of lymphocytes to antigenic challenge.

Moreover, it is certain that even in immunologically responsive hosts, the same antigenic conjugate might induce the synthesis of different types of antibodies and, consequently, a variety of allergic manifestations. Penicillin might predominantly produce anaphylaxis, but has been shown to produce—more so, lately—erythema, eosinophilia, or acquired hemolytic anemia. The incidence of periarteritis nodosa increased sharply during the sulfathiazole era of the mid-forties, and decreased sharply after the introduction of penicillin. Currently used sulfa drugs might produce granulomatous disease, occasional exfoliative dermatitis, and drug fever: this is approxi-



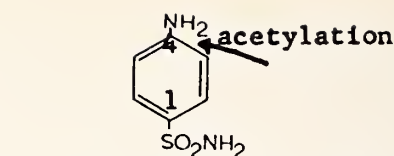
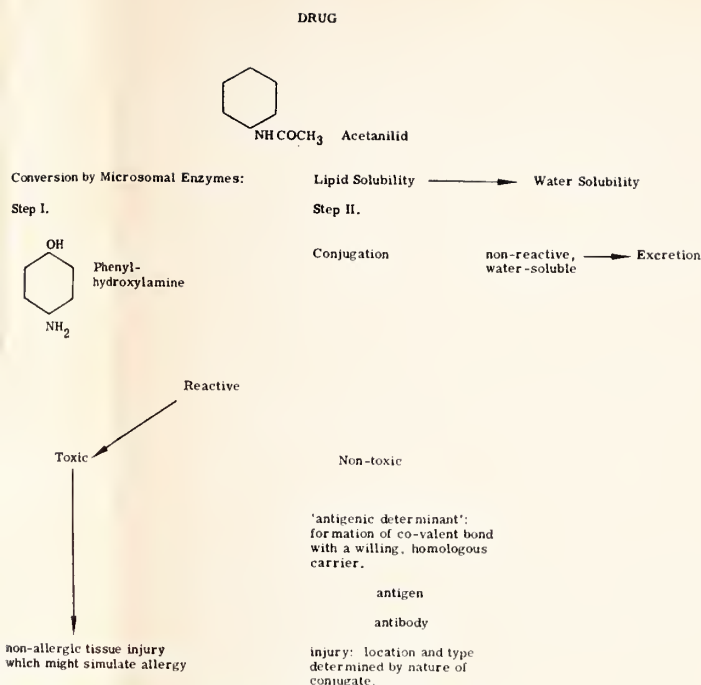
**Fig. II. Biotransformation of amphetamine (in the rat)**  
**Step I. Hydroxylation.**

### Step II. Conjugation with glucuronide.

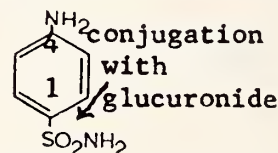
mately the same spectrum of symptoms which might develop after administration of p-aminosalicylic acid, but PASA has the additional distinction of inducing formation of "virocytes" which simulate infectious mononucleosis. In fact, it is not always certain that symptoms induced by drugs reflect hypersensitivity to drugs. The nature of the Stevens-Johnson syndrome—once attributed to diphenylhydantoin and long-acting sulfas—remains to be clarified; sulfa- and fava bean-induced hemolytic anemia occurs when red blood cells become vulnerable because of a genetic deficiency in glucose-6-phosphate dehydrogenase; and recent studies suggest that hydralazine does not *produce* an L.E.-like syndrome, but makes a latent systemic L.E. manifest.

### 'Abnormal' Metabolism of Drugs and Its Possible Reasons

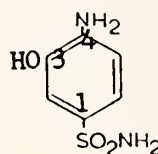
If—as some authors have suggested—"normal" biotransformation is less likely to yield toxic metabolites or haptens which conjugate to form antigens, it might be well to speculate about the possible reasons for "abnormal" handling of drugs. Some drugs are more reaction-prone than others; since chloramphenicol *must* conjugate with glucuronide, the absence of glucuronyl transferase will prevent "normal" biotransformation: this, of course, is the predicament of premature children. Fortunately, most drugs can metabolize through alternate pathways: it would be



or by N<sup>1</sup>-conjugation with glucuronide.



Other metabolites, however, exist; and it is conceivable that a comparatively small amount of an oxidized compound, 3-hydroxy-sulfa,



might be responsible for toxic as well as allergic reactions.

### Practical Considerations

How much can we predict? Some toxic reactions—e.g. the effect of thalidomide on the fetus during a limited period of early pregnancy—are inherent in the structure of the drug, and would be predictable if only we knew enough. If prescribed monoaminoxidase inhibitors prevent the deamination of vasoactive amines in foods like cheese and chianti, such foods, eaten at the wrong time, might precipitate vascular accidents. If drugs, by and large, are not dangerous because of what they are, but because of what they might become, the *host* is the decisive factor in the control of reactions to drugs. Every drug stimulates the enzyme system which is appropriate for its excretion; and some drugs, as phenobarbital, stimulate multiple enzyme systems: it is fair to assume, I believe, that the majority of reactions to drugs are caused by an inherited or acquired deficiency in enzymes which are essential for their biotransformation. Ideally, we need an enzyme "profile" for every patient; or even an enzyme "tolerance test" which would establish blood levels and urinary excretion of test compounds with known enzymatic requirements. The technical difficulties are substantial, but not insurmountable: sophisticated analyzers de-

**Fig. III Biotransformation of acetanilid.**

**Step I. Conversion of acetanilid to anilin, of anilin to phenylhydroxylamine: the reactive and toxic metabolite causes methemoglobinemia.**

frightening, indeed, if most or all of the drugs which are currently prescribed would have to compete for the same enzymes and for the same substrates. Studies on experimental animals have limited value because their evolution differs too much from our own: the excretion pattern of amphetamines in the rat (Fig. II) is *not* the excretion pattern of amphetamines in man. I am reminded of a lecture on hypertension by Eugene M. Landis—while he was still at the University of Pennsylvania—who said: "If a man has spent his entire life investigating the pharmacodynamics of hypertension on thousands after thousands of dogs, he should be expected to know a great deal about hypertension," and added wistfully, after a pause, "in dogs."

Man, however, is not a uniform species: pharmacogeneticists have shown that the hydrolysis of succinylcholine by pseudocholinesterase or the titer of acetylase which separates slow from rapid inactivators of isoniazid is under genetic control and part of the make-up of the individual.

In addition it appears that the "common" metabolites, i.e., the metabolites which are excreted preferentially, might not be the metabolites which cause toxic reactions. Sulfa drugs, for instance, are usually excreted either by N<sup>4</sup>-acetylation:

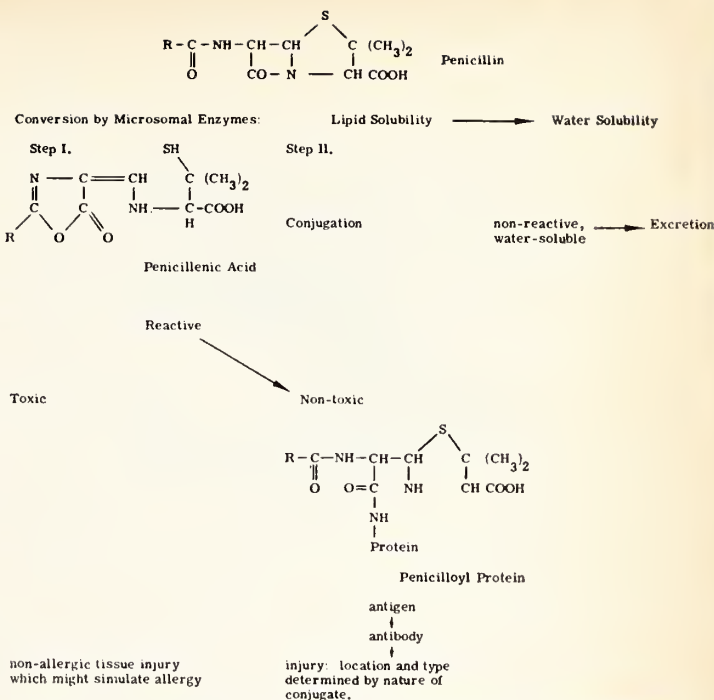


veloped at Oak Ridge National Laboratory can determine the presence of more than one hundred chemical components in a single specimen of urine; and only the cost of the analysis prevents its general application. Who would have guessed, in the twenties and thirties, that it would be possible, someday, to dip a single strip of paper into urine and determine, at the same time, protein, glucose, blood and pH?

Meanwhile, the abundance of drugs which are available, and which are taken, makes us justly apprehensive. Actually we do not have any precise information about the extent of the danger. Chloramphenicol, again, is a good example. Chloramphenicol and salicylates are excreted as glucuronides. Yet, chloramphenicol needs glucuronyl transferase much more urgently since salicylates have various options for conjugation and excretion: is it fair to say that the simultaneous administration of the two drugs will increase the possibility of toxic reactions from chloramphenicol? Our intuition says yes, but there are no experimental data to prove it. Even so, it might be an acceptable challenge to pharmaceutical manufacturers to prepare a chart which would designate drugs which compete for the same enzymes and the same substrates and—at least on theoretical grounds—should not be given at the same time. The word “challenge” has been used deliberately: as a rule, and in spite of extended investigation in experimental animals and man, the metabolic fate of new drugs is not very well known.

### In Conclusion

Pharmaceutical technology today confronts us with unlimited horizons: this is not an unmixed blessing. The predictability of drug reactions is limited, but not more so than the predictability of almost everything else. Weather, for instance, has become a subject of intensive investigation. We can seed clouds and produce rain. We can place satellites in orbit which will photograph and map currents and storms and report to computers. Forecasts, however, are as tricky as they have always been: it is surprising how seldom prediction and reality match. And the wise man might well take an umbrella when the forecast promises a clear and sunny day. The miracle of drug reactions is not that they occur, but—now that we have reached



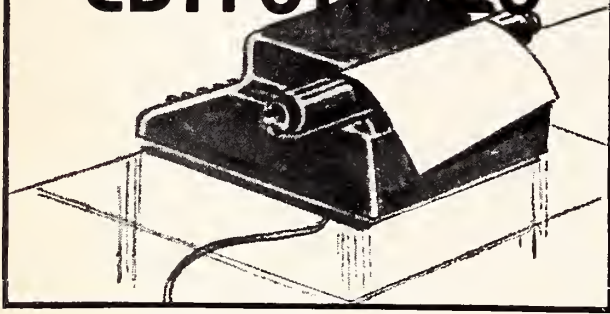
**Fig. IV** One of the alternate transformations of penicillin. Step I. Formation of penicillenic acid. The reactive, non-toxic metabolite forms a covalent bond with the lysyl residue: penicilloyl-protein.

Aldous Huxley's "brave, new world" and take tranquilizers "not by the billions, as they are at present, but by the scores and hundreds of billions"—that they are not many times as common as they are. In the end, it seems, our microsomes are ahead of our brains.

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1. O'Brien, W. M., "Drug Testing: Is Time Running Out?" *Bull. of the Atomic Scientist*, 25:8, 1969.
2. A review of a sequence of essays in this series suggests that the Editor considers 'Medical Progress' a forum for personal opinion which is not, as a rule, accompanied by a substantial bibliography. The author wishes to acknowledge his debt, however, to R. T. Williams (*DETOXICATION MECHANISMS*, London, Chapman and Hall, 1959); to B. B. Brodie and his associates who have clarified many of the basic mechanisms of "idiosyncrasy and intolerance"; to W. Modell who has been an eloquent spokesman for the profession without ever losing his sense of proportion; to W. Kalow, pharmacogeneticist; to C. W. Parker who has contributed painstaking studies about the manner in which penicillin becomes an antigenic determinant; to L. Meyler who aroused the conscience of his confreres by simply listing adverse reactions to drugs in yearly or near-yearly compilations; to the *Annual Review of Pharmacology*; to the Ciba Symposium: *DRUG RESPONSES IN MAN* (edited by G. Wolstenholme and R. Porter, Little, Brown and Company, Boston, 1967); and to H. F. Dowling who has taught me that the practical approach to the control of reactions to drugs might be far more demanding than the recognition of the biological circumstances by which they occur; and that one must never give up.

# EDITORIALS



## EXIT RUBELLA

The long awaited rubella vaccine has been licensed for immediate use in the United States. It is expected that the vaccine will prevent the periodic outbreaks of rubella like the one in 1964 when an estimated 1,800,000 cases occurred. From 10,000 to 20,000 infants suffered anomalies due to maternal rubella. The effective use of the vaccine should result in a significant decrease in the number of cases of congenital cataracts, congenital heart defects, deafness and mental retardation. The severe multi-system involvement seen in the acute congenital rubella syndrome of the newborn could be completely eliminated.

Certain indications for the use of the rubella vaccine are stressed. The vaccine should be given to both male and female children between one year and puberty with or without a history of having the disease. Children between 5 and 9 have the top priority because an epidemic in this age group is more likely to result in dissemination of rubella in the community.

The vaccine must not be given to pregnant women. It should not be given routinely to adolescent girls or women in the child bearing age group, unless safeguards against pregnancy are used and susceptibility to the disease is proven.

The vaccine will allay the fears of pregnant women about bearing infants with congenital anomalies; however rubella is only one cause of congenital anomalies. At least 11 other viral agents are believed capable of causing birth defects in infants.

The vaccine is being released at a time when cases of rubella have been reported in Illinois. Patients should be cautioned that the vaccine will not prevent rubella after exposure to the disease. Doctors should carefully read and follow the recommendations of the committee on Control of Infectious Diseases of the American Academy of Pediatrics for the administration of the rubella vaccine.

Harvey Kravitz, M.D.

## ALLEGED INCIDENTS

Medical societies should answer controversial editorials and stories in the lay press that are critical of our profession. There are two sides to every argument—all too often only one is told to make the item interesting and newsworthy. Now and then organized medicine should take the initiative and help the community solve a medical problem. The prompt response of

Dr. Ralph Dolkart, Dr. Fred Tworoger, and the Chicago Medical Society to the articles that appeared in the "Chicago Tribune" concerning the large fees paid to certain welfare physicians is a good example.

We should also investigate news items dealing with alleged misconduct of physicians or failure to provide adequate medical care. From time to time your editor



has tried to verify the names and addresses of people sending letters critical of the medical profession to the Voice of the People in the "Chicago Tribune." In many instances the names and addresses are phony. The letters are sent by cranks, leftists, or people wanting to get even with their doctor.

Verifying a pointed complaint is good public relations. Unfortunately, when they prove to be fake the damage usually has been done. This occurred to the State Medical Society of Wisconsin when they investigated a story that appeared in the "St. Cloud (Minnesota) Times" concerning alleged failure of certain Wisconsin physicians to provide adequate medical care to a welfare family. The article was written by reporter Bruce Nelson about a Mr. Robert Pastain and his family.

According to the story Mr. Pastain requested treatment for his infant daughter in St. Cloud. He stated that his baby was born in Tomahawk, Wisconsin, just days before and that he had been forced to leave within 2 hours after delivery because the hospital lacked welfare facilities. In addition, Mr. Pastain testified that he had been refused further medical care for the baby, whom he thought was ailing, at several Wisconsin towns because he lacked funds. He claimed that in one Wisconsin community the nurses to four doctors would not allow him to see the doctor when they learned he "couldn't pay."

The state medical society was concerned about the alleged incident and their attempt to verify the story has gotten nowhere. Meanwhile, they continue to get irate letters from the laity. Mr. Robert Pastain told the county welfare department in St. Cloud that at the time of the inci-

dent he and his family were on their way back from Flint, Michigan, where they attended the funeral of Mrs. Pastain's mother, whose maiden name was Doris Davis.

The medical society investigation revealed that there was no one by the name of Davis or Pastain who was involved in a Michigan funeral. Mr. Pastain told the welfare people that he came from Graham, Washington. In addition, he told them he lived on Route 2, but told the reporter he lived on Route 4. The Graham postmaster was contacted. He told investigators there was no record of a Robert Pastain or any similar name in or around Graham. Furthermore, there were only Routes 1 and 2 in this area.

There also were discrepancies concerning the telephone and Social Security numbers. The service station operator in St. Cloud, who supplied gasoline at the request of the welfare department, said the auto had a North Dakota license plate. Mr. Pastain also told the reporter that he called upon the Wisconsin State Highway Patrol for assistance, but the department had no knowledge of such an event.

The investigation also showed that no baby by that name was delivered in the hospital in Tomahawk, Wisconsin, and there is no record of the birth being documented.

The State Medical Society of Wisconsin wants help. We assume the alleged Mr. Pastain cooked up the story to get help from the welfare authorities who in turn thought it too good a story to keep a secret and called in Reporter Bruce Nelson. All were conned, but the medical society is holding the bag and has no recourse because the story is no longer news.

T. R. Van Dellen, M.D.

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"However attractive anarchy may be as a philosophy, it is not feasible in a world of imperfect men. Men's freedoms can conflict and when they do, one man's freedom must be limited to preserve another's—as a Supreme Court Justice once put it, 'My freedom to move my fist must be limited by the proximity of your chin.'"—from **Capitalism and Freedom** by Milton Friedman, professor of economics, University of Chicago.

# Enzymatic Treatment

## Of

### Fissure In Ano

BY TIBOR L. KOPJAS, M.D., PH.D./COLLINSVILLE

Fissure in ano is a slit like ulceration resembling a tear in the lining of the anal skin at and below the anorectal line. A fissure may appear in any portion of the circumference of the anal canal, but its usual site is the posterior midline, which represents the divergence of the unsupported muscle fibers, consequently the weakest point in the anal area. Lateral or multiple fissures are frequently caused by specific diseases such as tuberculosis, amebiosis, syphilis and gonorrhea.

This commonly encountered condition occurs in the median life, more common in females than in males; although it is not infrequent in infancy it is rarely found in the aged due to relaxed muscle tone.

Trauma caused by constipation, impaction, congenital narrowing of the anus and in inflammatory conditions caused by cryptitis, proctitis and papillitis are among the predisposing causes of fissure formation. Hemorrhoids and pruritus ani are frequently with fissures. Generally pain is the most definite symptom and is always increased with defecation. The typical pain and pain intervals are so characteristic that the diagnosis is not difficult.

A conservative treatment approach consisting of low residue diet, rest, sitz baths, systemic and local analgesics are generally used. Rest in most cases is voluntarily imperative since any motion may incite sphincter contractions which results in

great pain. Fissures caused by specific diseases requires systemic therapy. Surgery is indicated when palliative methods will not succeed in healing and when complications are found such as stenosis, deep crypt, hypertrophied papilla or sentinel pile. Very satisfactory and rapid healing in numbers of simple fissure sufferers was achieved with a topical ointment containing proteolytic enzyme.

#### Methods and Materials

In the past two years, 14 patients were selected (9 females and 5 males, whose average age was 36 years) with acute fissure in ano and were treated with enzymatic topical ointment. Each patient after careful examination was given a bland diet and instructed to follow it carefully. They were also instructed to take two sitz baths daily, and were given a prescription for a

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stool softener and a prescription for a topical ointment containing an equal amount of enzyme and analgesic, to be applied twice daily in the anal canal and not in the rectum. The patients were asked to report back in a few days for examination and evaluation of the therapy.

The enzymatic ointment preparation contained 1% proteolytic enzyme in water soluble base, derived from mammalian pancreas gland or from plant extract (papaya), and an equal amount of topical anesthetic (benzocaine) ointment.

### Results and Discussion

Eleven of the patients encountered for the first time their painful fissure in ano, and three patients had past history of one or two such painful episodes.

In an average of three days, all the patients had noticed relief from severe pain and in an average of five days the fissures were completely healed.

Repair of a fissure in ano, which is a superficial ulceration in the stratified squamous epithelium of the anal canal, as in all wounds, consists of the replacement of dead or damaged cells by new healthy cells. Wounds of any sort represent local areas of lowered tissue vitality. More extensive damage results in greater inflammatory response. Necrotic tissue debris and devitalized tissue constitute stimuli to an inflammatory reaction and places an ob-

stacle to tissue repair. Larger or longer standing tissue defect requires longer periods of time for healing, in many cases with inevitable scar formation.<sup>1-2</sup>

The complete and rapid healing was definitely attributed to the reparative enzymatic action of the locally applied proteolytic enzyme by debriding and cleansing the wound, thus lessening the inflammatory reaction and minimizing the tissue damage, therefore speeding the ultimate repair.

### Summary

Fourteen patients with acute simple fissure in ano were treated with an enzymatic ointment, containing 1% proteolytic enzyme in water soluble base, either plant or animal extract, with good results.

Patients followed a bland diet, took two sitz baths daily, a stool softener orally and applied ointment twice daily in the anal canal. In three days, the patients were free from severe pain and in five days the fissure was completely healed.

The good results was attributed to the proteolytic enzyme's cleansing action by debriding the wound. ◀

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1. Dible, J. H., "Inflammation and Repair," *Ann. Roy. Coll. Surgeons (England)*, 6:120, 1950.
2. Dunphy, J. E., and Udupa, K. N., "Chemical and Histochemical Sequences in the Normal Healing of Wounds," *New England J. Med.*, 253: 847, 1955.

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## WHY BELONG?

The following passage is excerpted from an editorial which appeared in the *Oakland County Medical Society Journal*. The author is a Birmingham physician.

"The medical society is not run by an establishment; it is run by default. The same individuals run the organization every year because they are the only ones willing to do the necessary work. The individual member may not agree with the viewpoints and policies of these men but no one will know until the individual comes to meetings and starts participating. Communication is perhaps the essence of the society. This has to be more formal than our preferred system of hearsay in the coffee shop and doctor's lounge.

"Writing to the editor is not all that hard, especially with present dictation systems; however, it happens seldom. Our representa-

tives to other organizations, such as Blue Shield, need very much to know what our local society's needs and wants are but they seldom find out because few take the time to communicate.

"Why should we bother to belong? It is simple. Medicine, although practiced by diverse individualists, has essentially only one organization to represent it. That organization starts at the county society level. Any medical individual who wants any say in that organization has to belong to it. In another aspect, any government body that is to deal with medicine will want to deal with its organized group, starting or finishing at the local society level.

"We must not only belong to our local medical society, we need to participate in it."

*Michigan Medicine*

## ***Looking for a Place to Practice?***

### ***Placement Service Lists Openings***

In an effort to reduce the number of towns in Illinois needing practicing physicians, the *Journal* is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

**PIATT COUNTY:** Mansfield; population: 800. Trade area: 2,000. Nearest physicians at Champaign, Farmer City and Bellflower, 20, 6 and 8 miles. Nearest hospital at Monticello, 16 miles. No drug store. Financial assistance if desired. Agricultural community. Methodist and Nazarene churches. Grade and high schools. Recreational facilities include golf, Lake of the Woods, 6 miles, Mansfield Park, Hickory Hill Hunt Club. Good fishing and hunting nearby. Excellent library. For details contact: Mrs. Genevieve Smith, Mansfield. Phone 489-2631.

**PIKE COUNTY:** Hull; population: 650. Several small towns in trade area without physicians. Nearest physician at Hannibal, Mo., 9 miles. Financial assistance if desired. Agricultural area. Churches: Methodist, Baptist, and Nazarene. Grade and high schools. Nearest recreational facilities at Hannibal, except for local bowling alley and lighted baseball field. For further information contact: Mr. Archie B. Gray, Hull.

**PULASKI COUNTY:** Karnak; population: 800. Trade area: 3,000. Town without a physician for many years. Nearest hospital at Metropolis, 20 miles. Nearest city, Paducah, Ky., 30 miles; population 30,000. No drug stores. Local Lions Club willing to

raise \$8,000 loan fund for a physician to draw from and assist in finding suitable housing and office space. Sources of income: agriculture and lumbering. Six Protestant and Catholic churches. Grade and high schools. Nearest country club at Mounds, 20 miles. For details contact: Allen Main or Curtis Cummins, Karnak.

**PUTNAM COUNTY:** Hennepin; population: 625. Trade area: 2,000. Industrial development underway involving 6,000 acres. Projected population over 5,000 within 2-3 years. Office space available. No physician; part time physician at Granville. Local drug store. Nearest hospitals at Princeton, 12 miles, and Spring Valley, 12 miles. Agricultural area. Methodist and Catholic churches. Consolidated Community high school. Six miles to nearest golf course. For further information contact: Rollo Parmenter, Hennepin.

**RANDOLPH COUNTY:** Prairie du Rocher; population: 700. Trade area: 4,000. No resident physician. Nearest physician and hospital at Red Bud, 12 miles; 63 beds. Belleville 32 miles. Missouri Pacific Railroad. Adequate office space and housing. Predominant nationality: French. Agricultural community. Stone quarries employ over 225. Near future location of Kaiser Aluminum. Catholic and Baptist churches. Grade and high schools. State Park 4 miles. Located on scenic river highway. For details contact: Mr. Gus Rako, Mayor, Prairie du Rocher, 62277.

**RICHLAND COUNTY:** Noble; population: 800. Trade area: 2,000. Office space available. Nearest hospital at Olney, 8 miles; 26 physicians on staff, 112 beds. Fully accredited. New homes for sale. Sources of income: oil and agriculture. Four Protestant churches. Grade and high schools. Vincennes, Ind. 40 miles. New Junior College, 8 miles. Nearest Country Club with golf course, 8 miles. Good hunting area. For further information contact: Mr. Harold Van Blarium, Noble.



# On The Quality

# Of The Physician's Life

By RICHARD D. CHESSICK, M.D./EVANSTON

*"The nature of man indicates that he can continue to learn all his life; the scientific evidence shows that he has the capacity to do so. Granting the overwhelming importance of early life in mental development, adult years are not without their opportunities. We know that brutalization and stupefaction can occur at any time of life. The way to stay human is to keep on learning."*

... R. M. Hutchins (*The Learning Society*)

This essay proposes to deal with the problem of brutalization and stupefaction in the life of the physician. It consists of reflections arising from the long term intensive psychotherapy of several physicians over the past 10 years and from my own personal maturation as a physician.

It is proposed to make a psychiatric contribution here not only to the quality of the life of the physician reader, but to the general notion of mental health.

Until now the importance of investigating the quality of an individual's life as part of assessing his mental health has not received the proper attention. As a clinician I have found it most useful to question patients rather closely about the details of their everyday living, with special attention to activities not directly connected with the necessities of life. Understanding the quality of the patient's life affords many clues to the genesis of numerous symptoms, both physical and psychological. It also contributes to a decision about the status of the patient's emotional maturity at the time of examination.

As Galbraith<sup>1</sup> and many others have pointed out, there is a great danger to all of us in today's "New Industrial State." This consists primarily of an overwhelming social pressure on us to devote all our waking moments to the goals of the industrial state, which are the production of goods and of income by progressively more advanced technical methods.

## Why We Should Resist

There are a variety of powerful arguments that militate against our letting this social pressure get the better of us. In the first place, when we slip into a life dedicated to the production of goods and income by progressively more advanced technical methods, we become slaves to the state in the extreme sense of the word. Galbraith compares it to "the benign servitude of the household retainer who is taught to love her mistress and see his interests as her own." So the socio-political objection is based on the loss of freedom involved in a life of this nature.

Second, an important medical objection also arises. The philosophy and culture of the West began when both the first attempts at understanding the world and the assigning of value to non-materialistic goods were made by the relatively sophisti-



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cated civilizations of Sumeria and Egypt. These were the first areas having sufficient amounts of wealth to allow the means and leisure for the support of speculation and art.

Today we are living in a civilization with material wealth far greater than ever dreamed of by the ancients, and yet we have less true leisure than the lowest ancient shepherds, who could play the lute and give names to the constellations. As Livingstone<sup>2</sup> comments: "The Greeks could not broadcast the Aeschylean trilogy, but they could write it."

### Wealth Accumulation

The major factor accounting for this is the great stress our civilization has placed on the acquisition of material wealth; as the value on these goods increases, the competition for them becomes keener and the tempo of life speeds up. In addition, our new industrial state has all the communication techniques at its disposal to manufacture and expand our wants. When this is coupled with the fact that work in such a state is less back-breaking, in the literal sense of the word, due to technological progress, machines and automation, it is not hard to see why the hours of work would tend to be increased in an effort to satisfy all the new wants.

Our fellow citizens begin to break down under such a pace, and doctors are plagued with lines of supplicants whose illness is simply a somatization of unhappiness.

### Affluence Can Lead to Unhappiness

An additional paradox concerning the same problem quickly unfolds itself with a little observation, and directly affects the lives of the physicians themselves. Greater affluence does not lead to more happiness or even to a more relaxed pace of life; the contrary is true. As the physician, for example, works his way up from the impoverished resident or intern to the middle-aged "pillar of the community," his life does not tend to become easier, and his expenses seem constantly to rise faster than his income. This law as a generalization has been formulated by the famous C. N. Parkinson.

Unless we are careful, therefore, we are faced with a form of slavery, the danger of psychosomatic breakdown, and increas-

ing economic pressures and unhappiness—amazingly enough in the face of constantly rising personal affluence. The solution to this dilemma forms the basis of this essay.

The foundation of this solution is to live a life of good quality. We must find a way to substitute for restlessness (at the bottom of which there sometimes appears to be a fanatical and even ultimately suicidal activity) the capability of seeing life as a whole and the world as a whole, and to act in accordance with this extended viewpoint. This can only be done by provision for an intelligent use of leisure time. Pieper<sup>3</sup> states,

*"The point and justification of leisure are not that the functionary should function faultlessly and without breakdown, but that the functionary should continue to be a man—and that means that he should not be wholly absorbed in the clearcut milieu of his strictly limited function; the point is also that he should continue to be capable of seeing life as a whole and the world as a whole; that he should fulfill himself, and come to full possession of his faculties, face to face with being as a whole."*

There are many other ways of stating the problem. For example, Schopenhauer saw men as driven by an unconscious "will" of imperious desire, always striving, never satisfied. As long as the consciousness is filled by the "will" there can be no happiness and no peace, only at best a respite from pain, which itself is often felt as boredom. He writes:

*"To see how short life is, one must have lived long . . . Up to our 36th year we may be compared, in respect to the way we use our vital energy, to people who live on the interest of their money; what they spend today they have again tomorrow. But from the age of 36 onward, our position is like that of the investor who begins to entrance on his capital . . . It is the dread of this calamity that makes love of possession increase with age."*<sup>4</sup>

Although insanity and suicide are discussed by Schopenhauer as ways of relief from the world of the strivings of "will," he also allows the possibility of relief



through use of the intellect to achieve wisdom and enjoy the arts:

*"A man who has no mental needs is called a Phillistine; he does not know what to do with his leisure—difficilis in otio quies (Quiet in leisure is difficult); he searches greedily from place to place for new sensations . . ."*<sup>4</sup>

The ultimate deliverance from servitude towards the "will" and material interest is found in the contemplation of art, according to Schopenhauer. His pessimism about man's captivation by the "will" would certainly be borne out by the recent trends in modern civilization towards worship of the material goods of life.

### **True Learning and Use of Time**

A 20th Century viewpoint perhaps more acceptable to the modern reader is stated by Robert M. Hutchins. In two important books<sup>2,5</sup> he extolls the advantage of cultivating the "intellectual virtues" and, quoting Bertrand Russell, "creating and sustaining a lofty habit of mind." The arch enemy of the use of leisure for such purposes in our culture seems to be the television set. Thus, either an individual can become so immersed in the producing and consuming aspects of our culture that he allows himself no leisure at all, or, if he does allow for leisure, it is used in the service of brutalization and stupefaction in front of the television screen rather than towards a development of human potential.

The purpose of true learning is to take part in the great conversation that has been going on since the beginning of recorded history regarding the really important matters of humanity. Describing this conversation, Hutchins writes:

*"It connects man with man. It introduces all men to the dialogue about the common good of their own country and of the world community. It frees their minds of prejudice. It lays the basis of practical wisdom . . . It implies the capacity to distinguish the important from the unimportant."*<sup>5</sup>

### **Basic Aspects to Living**

The notion of "cultivation of virtues of the intellect" deserves a more careful definition, especially with respect to the meaning of this procedure for physicians. In

my opinion there are three basic aspects to living the life of the mind for physicians.

The first of these is the simplest and most readily understood—it involves keeping up with the scientific field one has chosen and participating in the advancement of this field. A surprising number of physicians do not put time aside for deliberate continued self education in whatever their medical specialty or in general practice. A hurried perusal of drug-house "throw-aways" and the *J.A.M.A.* does not provide continued education in the field, if this is the sum total of activity towards self-education over a period of years. It is not relevant to this essay to instruct physicians on how to keep up; there are many well-known facilities for the continued self-education of physicians.

An even smaller percentage of doctors make any effort to contribute to the field. This is a great error for two reasons. Even the most modest contribution to the literature can turn out to be important in some unexpected way. Perhaps more importantly, the discipline of reviewing the literature on a subject and then attempting to write one's own contribution to the subject is an extremely valuable experience in self-education. Furthermore, it pervades the physician with the vital feeling of being a member of a scientific community rather than just a money-making technician.

The second aspect to living the life of the mind involves the contemplation of art. Here we come, of course, into direct conflict with the massive impact of tawdry and vulgar "entertainment" constantly at our elbow on television, movies, night clubs, etc. Probably the apogee of such intellectual bankruptcy is the "dinner-dance" so prevalent in our group. A flat-tasting and poorly served meal is presented to those still sober enough to eat, followed by boring speeches, vulgar noisy entertainment and dance "music." Each of us can name his own example of such nonsense; the point is that these activities compete for our "leisure" time—time that could be spent in the contemplation of the humanities.

It should be noted that I am not advocating a schizoid withdrawal of the physician from his friends and family. It is assumed that we are talking here about *leisure* time, that is to say, time deliberate-

ly set aside for cultivation of the intellect after ample time has been spent with family and friends. It is self-evident that such time must also be set aside and deserves prior consideration, and it is assumed that anyone who does not engage liberally in a healthy interaction with friends and family is mentally unhealthy. The point of this essay is that *something else* is also necessary—the setting aside of leisure time over and above the needs for rest, relaxation, friends and family!

This deliberately set aside leisure is used for the purpose of developing the human potential of the individual. In the physician it is used to further scientific education, to contribute to a chosen field of interest, no matter how modest the contribution, and to contemplate the field of the humanities—art, music, history, literature and grammar—in whatever proportion or combination the individual finds most satisfactory. This includes both the active participation in these fields, such as playing an instrument or writing a poem, or the passive contemplation—again whatever the individual finds most satisfactory.

The third and final aspect to living the life of the mind will perhaps be the most controversial. I believe that a person has not truly participated in the great dialogue of mankind unless he spends some effort on the subject of metaphysics. This highly controversial term is used here only in its simplest meaning—a study of first principles. One never finds an immutable or “true” meaning to life or any consistent metaphysical position that satisfies one throughout life, unless one is not really thinking about the subject and simply following dogma. In any person living the life of the mind, there must be time for contemplation about what is true, what is good and what is valuable, and for a study of what others have said on the subject. The particular solutions chosen at any given time, whether theological or anti-metaphysical, etc., are not the relevant issues—it is again the sense of gaining perspective on the human condition from such a study and the uplifting and humanizing feeling that results from investigating the nature of human life and its place in the universe, that counts.

## Education

Education is largely a matter of will. If a man is to be educated, he must want to be educated. He cannot be educated against his will and he cannot be forced to want to be educated, as Hutchins has pointed out. However, a person who refuses to deliberately provide leisure time for the three aspects of cultivation of the intellect discussed above cannot be called a healthy person. For he must be in the state Spinoza described in his chapter of *ETHICS* entitled “On Human Bondage”:<sup>6</sup>

*“A man who is submissive to his emotions is not in power over himself, but in the hands of fortune to such an extent that he is often constrained, although he may see what is better for him, to follow what is worse.”*

It is certainly clear that a life devoted to producing and consuming can lead only to brutalization and stupefaction. This obviously is not good for anybody. Furthermore, as physicians we have devoted our lives to the care of patients. It is self-evident that a lofty attitude of mind and a cultivated and thoroughly humane physician is going to be of far greater service to troubled humanity than a money-oriented or pleasure-oriented technician.

In the treatment of physicians my experience has been that, as the physician attains a greater maturity, his gross income begins to go down and more and more time is put aside by the physician—and his wife—for loving relationships and for development of their truly human potential. In taking an initial history on all patients it is useful to inquire into their personal goals and values as they manifest themselves in the patient’s actual behavior and investment of time and money—not in lip service in church on Sunday morning, etc. This sort of inquiry often yields a good measure of the maturity of the individual and clues to the genesis of many psychosomatic presenting symptoms.

## Summary

This paper has presented a warning to physicians unduly caught up in the world of production and consumption and a clue to the understanding of our patients with psychosomatic disorders who are similarly

*(Continued on page 202)*





# public affairs library reviews

THE PRINCE, Niccolo Machiavelli, Washington Square Press, New York, 1968 edition, 45¢ paperback.

For over 400 years, THE PRINCE has been the basic handbook of politics, statesmanship, and power. Written by a Florentine nobleman whose name has become a synonym for crafty plotting, it is a fascinating political and social document, as pertinent today as when it first appeared. Probably no single brief book will put the reader so immediately in touch with some of the central problems of our day. These central problems have to do with what is, or what should be, the relation of the citizen to the state, and what is, or what should be, the relation of the states to each other, and what the sources of and limits are, if any, to the power of the state.

Niccolo Machiavelli was born in 1469 in Florence. Setting out to write a practical guide to power, he chose as his model one of the most hated and feared despots of the Italian Renaissance—Cesare Borgia. Though himself one of Borgia's enemies, Machiavelli saw that this man's courage, daring and skill were the secrets of a successful government. Religion, morality and ethics he cast aside as mere stumbling blocks and hypocrisies in the way of a shrewd politician.

Lester G. Crocker, an eminent authority of Romance literature asserts: "THE PRINCE owes its great historical impact to two crucial viewpoints which inform it. In the first place, it treats all matters relating to politics and human behavior in general as purely natural phenomena, capable of objective analysis and control. In the second place, following this consistent naturalism, it considers success in achieving one's goals, in the personal or interstate struggle for survival, to be the only real or meaningful criterion of acts. Both these basic ideas are

developed throughout the book with a wealth of concrete examples and astute analytical reasoning."

In our own age, the broader philosophical significance of THE PRINCE seems more important than the narrower political program. The basic position is clear and unmistakable. Politics and morals are divorced. Each of the two has its own ends, each its own means, maintains Machiavelli. They are not reconcilable. There is no middle position of compromise. One is either a politician or a moralist, a ruler or a Christian. In the government of men and the dealings between governments, Christian morality is replaced by another set of values. Perhaps one may go as far as to assert a "political morality," set off against ethical morality—but Machiavelli does not even make such a claim. He is far from oblivious to ethical claims, but he considers that morality is itself an instrument of government, inasmuch as moral corruption in a people makes good government impossible. The civic virtues must be cultivated, and so morality is one of the political forces which must be reckoned with, and utilized—as religion is another. It is simply, then, that in THE PRINCE, all problems of justice are resolved into problems of mechanics.

There is no list of "great books" or of "books that have most influenced men's minds," on which Machiavelli's THE PRINCE does not appear. This is because THE PRINCE says so much that is true and deeply significant, because of its enduring influence, and because it is written in the most pure and vigorous prose. Much of modern political thought is based on Machiavelli's views on politics.

Spend some time on this book—it offers some exciting observations and stimulating premises.

*Read an interesting book lately? Write us a note and suggest its inclusion in the Public Affairs Library—Reviews. The Library appreciates your comments and suggestions.*



## Membership Forum

### WOMEN DRIVERS

Perhaps the oldest joke in 20th-century America is the woman driver put-on, according to The Travelers Insurance Companies annual booklet on highway accident statistics.

Of the 68,000 drivers involved in fatal accidents in 1968, only 10,000 were women.

However, a spokesman notes that "the big gun in this battle of the sexes is the canard that women are emotionally incapable of handling a car in an emergency. Or that an ignorance of anything mechanical makes it impossible for them to understand how to drive safely."

"Some women *do* get rattled easily," the spokesman concedes. "Some women *are* bewildered by nuts and bolts. And precisely the same can be said for some men," he added.

Statistics prove many reasons why cars crash: speed too fast for conditions; driving on the wrong side of the road; did not have the right of way; cutting into a line of traffic; passing on curve or hill; passing on wrong side; failure to signal and improper signaling; reckless driving, etc. Sex of the driver is not a proven reason.

"The fact is," the spokesman said, "there

are many more male drivers who drive many more miles than the average female. Until we have figures indicating the number of miles driven by male vs. female, the woman-driver joke will remain no more than a put-on."

*Ed. note: Membership Forum is a means for the ISMS physician to express opinion and viewpoint on varied topics. If you have an item you would like brought before your fellow practitioners, please submit it to Membership Forum, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601. Communications should not exceed 250 words. The right to abstract or edit is reserved. Names will be withheld upon request, but anonymous letters will not be accepted.*

**INFORMATION URGENTLY NEEDED**—concerning whereabouts of Wesley Harold Zahl, M.D. missing since April, while traveling from California to Wisconsin. A long-time resident of South Milwaukee, Wisconsin. A '41 Northwestern Medical School graduate, Dr. Zahl had lived in Burbank for the last 6 months. He is 67 yrs. old, ht. 5' 10", 160 lbs., hazel eyes (wears eyeglasses), a hemiplegiac without facial paralysis but with right arm in rigid flexed position and slight speech disturbance, walking with aid of cane—contact Cudahy Detective Bureau, Cudahy, Wisconsin 53110.

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### Film Reviews

"The Scream Inside . . . Emergence Through Group Therapy" is a new psychotherapy film just made available for qualified professional audiences. Presenting a wide range of psychotherapeutic group processes and dynamics on many levels, it includes actual therapy sessions with non-restricted patient conversation. Filmed to communicate concepts basic to an understanding of group functions and objectives, prints may be ordered from: Medical Film Dept., Sandoz Pharmaceuticals, Route #10, Hanover, N.J.

"The Federal Government and Cancer,"

a new 20-minute, 16mm. motion picture which presents timely information on cancer management and cancer research programs supported and directed by the government is now available. The film, produced during the recent meeting of the American Radium Society, was made to help physicians interested in cancer management understand the kinds of programs supported and encouraged by the government.

Prints may be borrowed from the American Medical Association, Film Library, 535 N. Dearborn, Chicago, 60610.



# Systemic Disease

## In Traumatic Splenic Rupture

BY JOHN W. POLLARD, M.D., HERBERT P. FRIEDMAN, M.D.  
AND JACK C. COOLEY, M.D./URBANA

*Rupture of the spleen is most commonly caused by trauma. Yet splenic rupture occurs in a small fraction of patients admitted to the hospital following injury. Certain patients, however, are predisposed to splenic rupture following trauma because of intercurrent disease affecting the spleen. The intercurrent disease may be overlooked at the time the patient is first seen because of prominent symptoms and signs of splenic rupture and the lack of symptoms and signs suggesting another disease is present. This case of splenic rupture following trauma in a patient with previously unrecognized infectious mononucleosis emphasizes the need to consider the possibility of intercurrent disease in patients with rupture of the spleen.*

### CASE REPORT

A 13-year-old white male was brought to the emergency room of the Carle Foundation Hospital at 6:15 p.m., in October, 1967, because of severe abdominal pain. While playing football that afternoon, he had been tackled in the epigastrium, had fallen to the ground, and immediately experienced increasingly severe epigastric and mid-abdominal pain. He was seen by his local physician and referred for further examination.

Physical examination revealed a well developed 13-year-old white male. His blood pressure was 130 systolic and 80 diastolic and the pulse rate was 106 per minute. The patient was not sweaty and there was no overt evidence of shock. Mild pallor was present. The examination of the head, neck and chest was normal. There was no cardiac murmur heard. The abdomen was tender in all quadrants; the left quadrant was the most tender. There was mild voluntary muscular spasm and mild rebound tenderness primarily referred to the left upper quadrant.

Complete blood count showed 11.6 grams of hemoglobin with 4.18 million cells per cubic millimeter. White blood count was 13,300 cells per cubic millimeter with a differential showing 55% neutrophils and 38% lymphocytes. Chest X-ray showed elevation of both leaves of the diaphragm. Abdominal X-rays showed scattered gas in the small bowel with no evidence of free air. Possible splenic enlargement was noted.

A four quadrant paracentesis was done in the emergency room under local anesthesia; no blood was obtained from any of the four quadrants. Following a sedative,

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John W. Pollard, M.D., (not pictured) is an internist specializing in cardiovascular disease. A graduate of the University of Minnesota

Medical School, he is a member of the American Board of Internal Medicine and the American Society of Internal Medicine. Herbert P. Friedman, M.D., (left) is a pathologist and laboratory director, Carle Clinic and Carle Foundation Hospital. A graduate of the University of Iowa, College of Medicine, Dr. Friedman is a past president of the Illinois Society of Pathologists and the Illinois Association of Blood Banks. Jack C. Cooley, M.D., is a chest and cardiovascular surgeon. A graduate of Northwestern University Medical School, Dr. Cooley is an assistant professor of surgery, University of Illinois, College of Medicine.



the patient seemed to relax and feel better. He was observed overnight. Fifteen hundred cc. of 5% Dextrose in saline was given slowly intravenously.

The abdomen was softer and less tender the next morning. There were bowel sounds present. Recheck of the blood count revealed only 9.9 grams of hemoglobin with 3.31 million red cells per cubic millimeter.

The white blood count was still 13,000 cells per cubic millimeter. The laboratory technician noted there were a few atypical lymphocytes present and that lymphocytes made up 24% of the total differential count. Amylase was within normal range. Because of the drop in hemoglobin and the X-ray which revealed an enlarged spleen, exploration was carried out.

At the time of exploration through a left rectus incision, approximately 200 cc. of free blood was found in the peritoneal cavity. A markedly enlarged spleen was seen in the left upper quadrant with a complete transverse fracture of its capsule. A large hematoma was present in the fracture preventing active hemorrhage. Curatory exploration of the remainder of the abdomen was within normal limits. A splenectomy was done with some difficulty, not only because of the size of the spleen, but because of the severe hemorrhage from the capsular fracture on mobilization. The patient was given two pints of blood during the procedure.

Post-operatively the patient's recovery was uneventful. Because of the atypical lymphocytes in the peripheral blood and the findings on pathologic examination of the spleen further questioning of the family was carried out. The mother stated that the patient had a severe respiratory infection approximately one month before the accident, and that she had noted an enlarged lymph node in the left side of the neck at that time. Bone marrow, blood

smear, and heterophile antibody studies post-operatively were diagnostic of infectious mononucleosis.

The patient was dismissed from the hospital after 11 days, in good condition. Complete blood count one week later showed 8,200 white blood cells with 45% lymphocytes. There were not as many atypical lymphocytes present as on the earlier post-operative differential test. The patient's energy level gradually returned to normal. He was dismissed to full activity feeling well in mid-December.

### Pathology Report

Grossly the spleen was enlarged measuring 21 x 11 x 8 cm. and weighing 550 grams. There were two lacerations dividing the spleen in thirds, one measuring 9½ cm. in length, and the other 10 cm. in length. (Fig. 1)

Microscopic examination of the spleen showed marked hyperplasia particularly of the reticuloendothelial elements. The follicles were atrophic and obscure. There was marked proliferation of immature elements which appeared to arise from the reticulum cells. There were free immature cells in the pulp as well as in the sinusoids. Many of these had large nuclei and rather clear vesicular prominent nucleoli. There were many mitotic figures. The sinuses were filled with cells of various degrees of maturation.

In summary, the spleen was pathologically enlarged with immature elements in the



Fig. 1. Lacerations are demonstrated in this picture of the gross specimen of the ruptured spleen.



sinusoids. Leukemia, agnogenic myeloid metaplasia, and infectious mononucleosis had to be differentiated by additional studies.

### Discussion

Rupture of the spleen was due to trauma and infectious mononucleosis in this case. Diagnosis led to surgical removal of the spleen and appropriate treatment for the infectious mononucleosis.

The diagnosis of ruptured spleen is suggested by a history of trauma and the presence of abdominal pain, especially left upper quadrant abdominal pain.<sup>1</sup> The pain may be referred to the left shoulder (Kehr's sign).<sup>2</sup> A history of trauma is not always present, as rupture of the spleen may occur spontaneously or secondary to disease of the spleen.<sup>2-3</sup>

Dropping blood pressure, rapid pulse, and skin pallor reflect the blood loss which occurs in splenic rupture. Abdominal findings include distension, tenderness, guarding, and rebound tenderness often more pronounced in the left upper quadrant. Non-shifting dullness may be present in the left flank and shifting dullness in the right flank (Ballance's sign).<sup>2</sup>

Decreasing hematocrit and leukocytosis occurs with blood loss into the abdominal cavity. Helpful X-ray findings are an enlarged spleen, elevation of the left hemidiaphragm, and downward displacement of the splenic flexure of the colon.

Treatment of ruptured spleen is surgical removal of the spleen as soon as the diagnosis is made. Of course, blood loss should be corrected and necessary supportive measures utilized as necessary. The rupture may be sudden with massive intra-abdominal bleeding requiring immediate blood replacement and surgery, or may be delayed over a one to three day period. In patients with delayed hemorrhage, the formation of a subcapsular hematoma may temporarily control the bleeding.

Infectious mononucleosis contributed to rupture of the spleen in the case presented. Cellular infiltration of the spleen with dissolution of the usual splenic architecture seen in this condition predisposes to rupture.<sup>4-6</sup> The spleen is enlarged in 50% of patients with infectious mononucleosis and is almost always enlarged when rupture occurs. Rupture of the spleen may result

in alteration of the differential white blood cell count from that usually seen in infectious mononucleosis because of the production of polymorphonuclear cells. Splenectomy does not adversely effect the outcome of infectious mononucleosis as most patients recover uneventfully.<sup>4</sup>

Many diseases other than infectious mononucleosis predispose to traumatic rupture of the spleen. Malaria and typhoid fever as well as infectious mononucleosis are the most commonly recognized of these conditions.<sup>4</sup> Other diseases which have been reported to predispose the splenic rupture include leukemia, portal vein thrombosis, Banti's disease, splenic infarction, puerperal sepsis, relapsing fever, pancreatitis, viral hepatitis, kala azar, echinococcosis, leptospirosis, syphilis, yaws, actinomycosis, tuberculosis, sarcoidosis, Gauche's disease, amyloid, thrombocytopenic purpura, and acute hemolytic anemia.<sup>2-3,7</sup> These diseases should be considered and excluded in patients presenting with traumatic rupture of the spleen.<sup>8</sup>

### Summary

A case of traumatic rupture of the spleen in a patient with infectious mononucleosis has been presented. The diagnosis of splenic rupture was made by the history of trauma and findings suggesting intra-abdominal bleeding. Infectious mononucleosis was suggested by pathologic examination of the spleen and confirmed by blood smear examination and heterophile antibody titer. The possibility that intercurrent disease is a contributing factor in patients with traumatic rupture of the spleen is emphasized. Infectious mononucleosis, malaria, and typhoid fever as well as other diseases may predispose to traumatic rupture of the spleen. ◀

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(Continued on page 204)

# Jacksonville

## First In State Institutions

BY FRANK B. NORBURY, M.D., F.A.C.P./JACKSONVILLE

Visitors to Jacksonville often comment on the location there of three huge State Charitable Institutions, all well over 100 years old and all presenting an interesting blend of various styles of institutional architecture of the 19th and 20th Centuries. These are the Illinois School for the Deaf (founded 1839), the Jacksonville State Hospital (1847), and the Illinois Braille and Sight-Saving School (1849).

Why were all of these institutions located in Jacksonville? There existed in Jacksonville in the early part of the last century a particular combination of enlightened idealism and practical politics which led to the development of these institutions. Citizens of Jacksonville at that time were vitally interested in education and also were represented in the Legislature by an outstanding group of men.

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Frank B. Norbury, M.D., is a Jacksonville internist. A graduate of Washington University Medical School, St. Louis, he was the 1967-68 chairman of the Morgan County Committee for the Illinois Sesquicentennial. He is certified by the American Board of Internal Medicine and a member of the American Society of Internal Medicine.



Jacksonville was founded in 1825, just seven years after Illinois became a state, and was located in an area in which there was natural migration of the population in the early days of statehood. Central Illinois was a meeting ground for settlers both from the North and the South. Even today, U.S. Highway 36 (on which Jacksonville is located) can be called the "Mason-Dixon Line of Illinois." Above this line the influence is distinctly Northern, below Highway 36 the influence is Southern.

Persons of intellect and ambition from both North and South settled this region and by 1837, Morgan County was the most populous county in the State. These early settlers founded Illinois College in 1829 and pioneered in the education of women by establishing a Ladies Education Society in 1833. They were also pioneers in the development of public schools. A community of intellectually and socially concerned persons was well-established within ten years of the founding of the City.

Jacksonville's political influence in the Legislature was great because of the size of the community and also because of the caliber of men sent by Morgan County in the early days. These included Joseph Duncan, Newton Cloud, John Henry, Stephen A. Douglas, and especially William Thomas. Thomas served first in the Senate from 1834-40 and was so influential that most of the other state senators submitted bills to him for an opinion before they



were even introduced. One of these was a bill to establish a State School for the Deaf. The originator of the bill, an Adams County Senator, had left a blank space for the location of the school in the bill he submitted to Thomas. Judge Thomas wrote "Jacksonville" in the blank space and then went to work and saw that the bill was passed. The citizens of Jacksonville cooperated and donated six acres for the school which was established in 1839.

By the 1840's, Illinois College had a medical school. One of the professors was Edward Mead, a pioneer psychiatrist, who came to Jacksonville in 1845. He was familiar with mental hospitals in the East and in talks with Thomas and others began to promote a mental hospital for Jacksonville. Mead toured the state, speaking to medical and other groups, and wrote over 700 letters to influential persons in behalf of the plan. By 1846, the campaign for the hospital was well underway, but the Legislature was not convinced of the need for a mental hospital. The Jacksonville group then invited Dorothea Lynde Dix to come to Illinois. Miss Dix was one of those indefatigable Victorian women like Florence Nightingale and Clara Barton. Starting in her home State of Massachusetts, she campaigned up and down the land in behalf of improved care for the mentally ill and her influence was ultimately successful in 15 states.

When Miss Dix came to Illinois, William Thomas, now back in the Legislature as a Representative from Morgan County, acted in her behalf. He saw that she met all of the members of the Legislature in small groups and at the same time promoted the hospital for Jacksonville.

Miss Dix was very convincing and the Legislature was determined to build a mental hospital. But somewhere along the way, something happened which led to a disagreement between her and Judge Thomas. She was soon working with C. H. Constable on a Senate bill to locate the hospital in Peoria. The bill actually passed the Senate in this form, but in the House Thomas' influence was so strong that he

had the House Bill changed to read "Jacksonville" instead of "Peoria." The conference committee agreed with Thomas and the hospital was built in Jacksonville in 1847.

The third institution, the Illinois Braille and Sight-Saving School, was the inspiration of Samuel Bacon, himself a blind man of remarkable ability. He established a private school for the blind in Jacksonville in 1848, and then began efforts to have the State take it over. Bacon became a close friend of William Thomas. Thomas was no longer in the Legislature, but he drew up a bill for state operation of Bacon's school anyway and had Richard Yates (then a Morgan County Representative and later Civil War Governor of Illinois) introduce it. It passed in 1849.

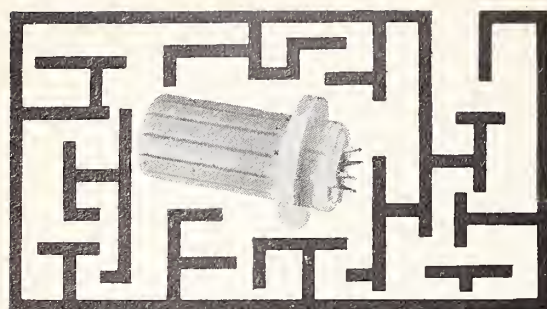
Jacksonville was briefly the site of another state institution. What is now the Lincoln State School for the Mentally Retarded was established in Jacksonville in 1871, but was moved to Lincoln in 1878. Jacksonville also tried very hard to become the location of the University of Illinois. Jonathan Baldwin Turner of Illinois College promoted a State University for many years and is considered one of the prime movers in establishing Land-Grant Colleges. However, by the time the University of Illinois bill was introduced in the Legislature, the citizens of Champaign County had learned a few things from Morgan County and the University was established there instead.

This account of the State Institutions of Jacksonville is not written entirely for its historic interest. Today in 1969, various groups in the State are interested in promoting new state institutions including medical schools. Jacksonville is not in the running for any of these. But the formula used by Jacksonville over 100 years ago might still be useful to those who are now promoting institutions for their communities. 1) Get together a group of interested and informed citizens. 2) Bring in newsworthy persons to promote the cause. 3) Develop influential friends in the Legislature. ◀

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# 1969 President's Tour

The busy physician, the physician's wife, and medical assistants, will soon be offered the opportunity, through specially designed symposia, to meet and discuss concerns, learn of increased opportunities, and better equip themselves to meet the challenges of today's frenetic pace.

Combined with the annual District Meetings, the 1969-70 President's Tour promises to be inspirational and stimulating. Edward Cannady, M.D., ISMS President, will hop-scotch the state on this third annual excursion to meet the Illinois physician in his own backyard. The ISMS story will be told by Dr. Cannady as he seeks to help meet the needs of medicine in Illinois today. While primarily meeting various physician groups, Dr. Cannady will also address many civic and community organizations in an attempt to enlist their aid in expanding medical care.

In addition to Dr. Cannady's tour, Mrs. Sherman C. Arnold, President of the Auxiliary to the Illinois State Medical Society, will meet in District meetings of the Auxiliary. These have been scheduled concurrently in most districts with the ISMS President's Tour.

While the Doctor and his wife are participating in the affairs of their respective organizations, educational programs have been put together for the medical and office assistants. These will enhance the efficiency and effectiveness of the assistant.

The tour package will follow a similar format in most meetings. Modifications will be made, however, to fit the needs of local host counties and cooperating groups. Initial plans indicate that a Financial Planning Workshop will be conducted for the physician and his wife starting at 2 p.m. At the same time a workshop on Office Practices will be held for the medical assistants. At 3 p.m. the doctor's wife will move to a District meeting of the Auxiliary; physicians will continue with financial planning. At 4:30 p.m. a Public Affairs program for the physician and his wife will be conducted. During this same time slot, Dr. Cannady and the District Trustee will meet with the presidents, secretaries, delegates and alternate delegates from each of the counties in the district. This will afford opportunity to share mutual problems and concerns.

A No Host Reception at 6 p.m. will precede the 7 p.m. dinner at which ISMS President Cannady will be the keynote speaker.

The Tour schedule includes stops all across Illinois. Since some physicians may have difficulty, for various reasons, in attending the meeting in their own district, such are encouraged to attend the Tour meeting in a neighboring district. For information about any of the meetings, inquiries may be addressed to your District Trustee, to the host county, or to ISMS Headquarters.

Planned meetings, as of this writing, include the following stops:

**September 17**—11th District; at Elmhurst Country Club, Wooddale; Host—DuPage County Medical Society.

**September 25**—2nd District; at Holiday Inn, Peru; Host—LaSalle County Medical Society.

**October 9**—8th District; at Champaign Country Club, Champaign; Host—Champaign County Medical Society.

**October 16**—6th District; at Holiday Inn, Quincy; Host—Adams County Medical Society.

**October 22**—1st District; at Pheasant Run, St. Charles; Host—Kane County Medical Society.

**October 30**—7th District; at Decatur City Club, Decatur; Host—Macon County Medical Society.

**November 6**—9th and 10th Districts; at Augustine's, Belleville, as part of Southern Illinois Medical Association Annual Meeting; ISMS President Cannady will meet at 3:30 p.m. with county medical society officers and delegates.

**March 26**—5th District; Host—Sangamon County Medical Society.

**April**—4th District; Host—Peoria County Medical Society.

Meetings in the 3rd District will be scheduled in the near future.

All physicians are urged to attend these important gatherings. Activities for the doctor's wife will help her in maintaining an awareness of current activities. The Office Practices Workshop for assistants will help the medical assistant become more proficient in her duties.

## *Clinics for Crippled Children Scheduled*

Twenty-seven clinics for Illinois' physically handicapped children have been scheduled for September by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 21 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing service. There will be three special clinics for children with cardiac conditions and rheumatic fever, and three for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- Sept. 3—Rock Island, Cerebral Palsy—3808 Eighth Avenue  
 Sept. 3—Hinsdale—Hinsdale Sanitarium  
 Sept. 3—Carmi—Carmi Township Hospital  
 Sept. 4—Peoria, Cerebral Palsy (A.M.) — St. Francis Community Clinic Area  
 Sept. 4—Effingham, General—St. Anthony Memorial Hospital  
 Sept. 4—Sterling—Community General Hospital  
 Sept. 9—East St. Louis—Christian Welfare Hospital  
 Sept. 9—Peoria, General—Children's Hospital

- Sept. 10—Joliet—St. Joseph's Hospital  
 Sept. 10—Champaign-Urbana — McKinley Hospital  
 Sept. 11—Springfield, General—St. John's Hospital  
 Sept. 11—Anna—First Christian Church  
 Sept. 11—Macomb — McDonough District Hospital  
 Sept. 12—Chicago Heights, Cardiac — St. James Hospital  
 Sept. 17—Jacksonville—Norris Hospital  
 Sept. 17—Evergreen Park—Little Company of Mary Hospital  
 Sept. 18—Sparta—First Baptist Church Educational Building  
 Sept. 18—Elmhurst, Cardiac — Memorial Hospital of DuPage County  
 Sept. 18—Decatur—Decatur Memorial Hospital  
 Sept. 18—Rockford — Rockford Memorial Hospital  
 Sept. 23—Belleville—St. Elizabeth's Hospital  
 Sept. 23—Peoria, General—Children's Hospital  
 Sept. 24—Elgin—Sherman Hospital  
 Sept. 24—Centralia—St. Mary's Hospital  
 Sept. 24—Springfield, Cerebral Palsy—Diocesan Center  
 Sept. 26—Chicago Heights, Cardiac—St. James Hospital  
 Sept. 30—East St. Louis—Christian Welfare Hospital

### **WAGE AND SALARY COMPARISON**

Recently a study was conducted of union-oriented tradesmen.

Carpenters .....	\$4.44 per hour (40 hour week)
Electricians .....	\$5.50 per hour (40 hour week)
Plumbers .....	\$4.94 per hour (40 hour week)
Linotype Operators .....	\$4.20 per hour (36 hour, 40 minute week)
Bricklayers .....	\$5.40 per hour (40 hour week)

Based on this and computing on a basis of 40 hours straight time and 48 hours overtime, for which time and a half is paid, we arrive at the following annual income figures:

	<i>40 hour week</i>	<i>88 hour week</i>
Carpenters .....	\$ 9,235.00	\$25,858.00
Electricians .....	10,504.00	29,424.00
Plumbers .....	10,275.00	28,770.00
Linotype Operators .....	8,736.00	24,460.00
Bricklayers .....	11,232.00	31,450.00

The 88 hour week figure used is based on an hypothetically extended average work week of a practicing physician.

*From the Maryland State Medical Journal*



# 3

Polymyxin B—Bacitracin—Neomycin

# against 10



Pseudomonas



Hemophilus



Klebsiella



Aerobacter



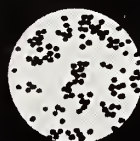
Escherichia



Proteus



Corynebacterium



Staphylococcus



Streptococcus



Pneumococcus

## 'Neosporin'<sup>®</sup> Ointment Polymyxin B—Bacitracin—Neomycin

Overlapping, broad bactericidal coverage.

Nonirritant ointment base; also enhances spreading and penetration.

Each gram contains:

'Aerosporin'<sup>®</sup>

brand Polymyxin B Sulfate . . . . . 5,000 Units

Zinc Bacitracin . . . . . 400 Units

Neomycin Sulfate . . . . . 5 mg.

(equivalent to 3.5 mg. Neomycin Base)

Special White Petrolatum . . . . . q.s.

**Contraindications:** This product is contraindicated in those individuals who have shown hypersensitivity to any of its components. Do not use in the external ear canal if the eardrum is perforated.

**Precautions:** As with other antibiotic products,

prolonged use may result in overgrowth of non-susceptible organisms, including fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

**Available:** Tubes of 1 oz., 1/2 oz. with applicator tip, 1/8 oz. with ophthalmic tip. The ointment base and the formula of the various sizes are identical, but only the 1/8 oz. tube should be used for ophthalmic purposes.



**BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York**



## **Wanted: More Medical Assistants**

BY SANDRA BREDTHAUER, CMA/ELGIN

More trained medical assistants are needed every day to help with the ever-increasing work load in the medical field. One can pick up any newspaper in the country and find an advertisement for a medical assistant.

Physicians and active medical assistants should encourage young people to enter the medical assistant profession in order to alleviate the shortage of personnel.

Any qualified young person wishing to pursue a career as a medical assistant may apply for a scholarship loan through the Maxine Williams Scholarship Fund, sponsored by the American Association of Medical Assistants' Endowment. This foundation was established in October, 1968, to administer the scholarship fund.

Participants in the loan program may borrow up to \$300.00 for their education. As a service to the profession, AAMA assumes all administrative costs so there is no interest on the loan. If the recipient spends a minimum of two years in the medical assisting field, the loan becomes an

outright scholarship, and no repayment is required.

The fund, named in honor of Miss Maxine Williams, AAMA's first president, is supported entirely by private donations from state medical assistants associations as well as local chapters. Contributions are tax deductible as an educational expense.

To be eligible for a loan, one must be a high school graduate who wishes to take formal training in medical assisting. At the present time, AAMA is working with the American Medical Association on an approval program, eventually leading to a standard medical assisting curriculum. The suggested two-year program recommends both administrative and clinical training for an Associate Arts degree at an accredited community or junior college.

Application blanks and information about the Scholarship Loan Fund may be obtained from American Association of Medical Assistants, 200 East Ohio Street, Chicago, Illinois 60611.

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## ***School Sports Examination Guide***

As an aid to physicians administering medical examinations for athletes, the American Medical Association has published "A Guide for Medical Evaluation of Candidates for School Sports."

Formulated by the AMA's Committee on the Medical Aspects of Sports, the pamphlet recommends that local school officials and medical society representatives jointly work out arrangements that offer optimum medical guidance for each athlete.

The six-page pamphlet contains a sample health history to be completed by the

student and his parents. An entire page is devoted to a suggested health examination form for use by the physician when conducting the medical examination.

An added feature of the pamphlet is a list of disqualifying conditions for participation in contact, noncontact or endurance and other types of sports.

Copies may be obtained from the AMA Order Handling Unit at 25¢ each; 23¢ each in lots of 50-99; 21¢ each in lots of 100-499; 19¢ each in lots of 500-999; and 17¢ each in lots of 1,000 or more.



# practice management *NEWS*

*A Service of the Public Relations and Economics Division*

## Simple Time-Saver: An Office Manual

BY MARIAN THIELE

The departure of a key employee can throw an office into temporary chaos, unless one is prepared to train new personnel quickly and efficiently. The greatest aid during this transition period may be an office manual.

By providing the new employee with an office guide, one saves time explaining unfamiliar duties. Instead of relying strictly on memory, everything expected of the new assistant will be written down in detail.

Besides providing job continuity, a manual can help improve office management in other important ways. If one employs several assistants, it can eliminate overlapping duties. In group practice, the manual supplies a written record of office policies and standardizes duties for all employees. By

reviewing the manual periodically, one can easily spot outdated office procedures that should be changed or eliminated.

If you agree that your office needs a manual, how do you begin? Start by listing office policies and have staff members list their job responsibilities and routines. If the office has staff meetings, refer to the minutes for items which might have been overlooked.

Keep the manual handy and encourage employees to use it whenever they have questions. If procedures change, be sure to amend the manual.

You'll probably find that each procedure falls into one of several general categories, such as:

- Job descriptions (duties and responsibilities of each staff member)
- Personnel policies (office hours, time off, sick leave, personal appearance requirements, vacations, employee benefits, etc.)
- Methods of completing forms and preparing letters (with examples of both)
- Special instructions on handling:
  - Emergency cases
  - Appointments (approximate times allotted to each type of patient, "drop-ins," return appointments, follow-ups on annual physicals or patients failing to keep appointments)
  - Telephone calls (those you want to take or prefer the medical assistant to intercept)
  - Outside consultants or advisors (management consultants, insurance agents, attorneys, accountants, collection agencies)
  - Billing and credit (fees, etc.)
  - Salesmen and drug detail men
  - Supplies (ordering and storing)
  - Office equipment.

# SOCIO ECONOMIC *news*

*A service of the Public Relations and Economics Division*

BY JOSEPH LOTHARIUS

## **IDPA Clarifies HEW's New Policy on Fees**

New HEW restrictions on fees will have little or no significance for Illinois' physicians. "At the present time there is no anticipated roll back in fees which Illinois is currently paying for physician's services," says Robert G. Wessel, Chief Medical Administrator for IDPA in a letter to ISMS. Mr. Wessel responded to an ISMS request for additional clarification of the recent HEW policy release on reasonable charges for individual practitioner's services.

"The new regulations require states to have information available to enable them to set maximum fees based on geographical areas, if appropriate, which accommodate not more than 75 percent of the practitioners in such areas." This release (from HEW) is a new definition of prevailing fees in the community and it was in no way indicated that states must make a 25 percent reduction in the allowances currently being paid to the individual physician.

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## **Caution Suggested When Contributing to Annuity Program**

The Human Sciences Foundation, Inc. is contacting physicians in Illinois with some sort of program for gathering medical statistical information for which the physician is given a free supply of vitamin supplements for distribution to his indigent patients. The physician is also allowed to contribute up to 30% of his income for the purpose of an annuity, which is returned to him at a tax saving. A Foundation representative has contacted ISMS and AMA, but it is impossible for either to formulate an opinion. The information given was very sketchy with no documentation of any consequence. ISMS' suggestion to those physicians contacted, is to get a complete explanation with proper documentation and then consult with an accountant and attorney before investing any funds.

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## **ISMS to Evaluate Physician Services Under Medicaid**

Two sub-committees of the ISMS Medical Advisory Committee to the Illinois Department of Public Aid are evaluating services of all physicians who received \$25,000 or more in medicaid payments last year. Dr. Fred A. Tworoger, president of the Chicago Medical Society, has been named to head the sub-committee that will be responsible for the Chicago area. Dr. Charles E. Baldree, Jr., Belleville, will head the sub-committee responsible for all other areas of the state. The two sub-committees will make their find-



ings known directly to IDPA. Physicians found to be abusing the medicaid program will be dropped from participation by IDPA.

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### **How "Truth In Lending" Affects Illinois' MDs**

The Federal Truth in Lending Act which became effective July 1, 1969, will only directly affect those physicians who make any additional charge over and above their regular fee for delayed payment of any bill. If such a charge is made it must be clearly explained on the statement so that any such financing charge or interest or any other charge for delayed payment is clearly explained.

*(Editor's Note—A more detailed article on the new Truth in Lending Act will be published in a future issue of the Illinois Medical Journal.)*

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### **ISMS Sponsored Malpractice Program Enjoys 40 per cent Growth**

The Professional Liability (Malpractice) program sponsored by ISMS recently celebrated its first anniversary and reported a 40 per cent increase in policies issued during the final quarter of the year. According to a participation report issued by the plan's administrator, Parker-Aleshire Co., present membership in the plan includes 66 per cent from Cook county and 34 per cent from other areas of the state. The plan's distribution by age shows 2 per cent over 80 years, 9 per cent over 70, and 18 per cent over 60 years of age. Participants below 60 years accounted for 71 per cent. The ISMS sponsored program provides coverage regardless of age or specialty. No policy can be declined or cancelled without ISMS review.

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### **Above Average Pay for Midwest Interns & Residents**

Interns and residents in the midwest receive above average salaries, according to a recent survey conducted by the Association of American Medical Colleges. The survey revealed that the national average salaries paid to interns and first-year residents were \$6,400 to \$6,900 respectively during 1968-69. Anticipated increases to \$7,200 and \$7,700 are expected in the 1969-70 academic year. Twenty-three percent of the questionnaire respondents indicated salaries paid interns and residents in their institutions varied because of the influence of federal grants or fellowships and departmental funds used to increase salaries for specific specialties.

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"What I fight for now is a dream, something that has never been on this earth since men first worked it with their hands, something that has never existed, and will never exist, until we can make it and put it here—the right of freeborn men to govern themselves, and to make decisions, and to organize their lives in their own way."—George Washington at Valley Forge.

### **Your ISMS Insurance Questions:**

**QUESTION:** *In an alleged malpractice situation, what is the single most important item a physician can offer as evidence in his defense?*

**ANSWER:** He should be able to produce scrupulous records on every patient. Records should be made during or immediately after each patient is seen. Such vital information as date of visit, diagnosis, medication prescribed, treatment, and any consultation data should be meticulously recorded.

**QUESTION:** *What coverage is afforded under the ISMS approved malpractice liability insurance program for the physician in corporate practice?*

**ANSWER:** The policy provides a separate set of applicable limits of liability for the corporation in addition to the limits applicable to the individual practitioner at no additional premium charge, provided all members of the corporate practice are insured under policies issued under the ISMS approved program.

*Do you have a question of general interest on any ISMS-sponsored insurance program: Retirement Investment, Keogh, Group Disability, Group Major Medical, Professional Liability (Malpractice)? Send it to this column: "Your ISMS Insurance Questions," Illinois Medical Journal, 360 North Michigan Avenue, Chicago, Illinois 60601. The column is a service of the ISMS Committee on Insurance.*

### **Effective Medical Treatment**

If the profession of medicine is to hold responsibility for treating disorders of human behavior, one would hope that effective treatment methods could be provided. At present, effective medical treatment methods are simply not available for criminal or violent behavior, alcoholism, drug addiction, sexual deviation, juvenile delinquency and a host of other disorders of human thinking and physical conduct. As a consequence, allied professionals have entered the treatment arena to "help." Educators, counseling psychologists, rehabilitation workers, self-help groups such as Alcoholics Anonymous and groups of interested lay workers and volunteers currently grapple with the treatment of deviant or maladaptive human behavior. Each group lays claim to special competence and modest success for its efforts. Often enough the claims to success are not backed up with the controlled studies that medicine has come to expect of its own therapeutic efforts. As a result, modest sums of money from public and private sources flow into treatment facilities of unknown effectiveness. Public insistence on immediate social action despite the absence of alliance between science and social reform has brought requests even from leaders in the medical profession that we extend services before their effectiveness is proved, judging their efficacy as we go along. Generally, medicine asks for more research because effective medical treatments are not available. Allied professionals and social reformers insist on maintaining the dignity of the individual patient despite the patient's insistence on destroying that same dignity through his deviant behavior. ("Human Behavior, Medicine and Social Reform," Editorials, *The New England J. Med.* 280:25 [June 19] 1969, pgs. 1415-1416.)



# The longest-acting thiazide antihypertensive... 24 to 48 hours

Thiazides are established drugs of first choice in essential hypertension. Among them, Renese is the thiazide with diuretic activity of 24 to 48 hours duration.

Low, low dosage—Renese controls hypertension in some patients on as little as one tablet every other day.

Low, low cost—Renese is less per day than most brands of antihypertensives.

Renese-R—offers *true* once-a-day dosage and combines the advantages of Renese (smooth and moderate regulation, good toleration, low-dosage economy) with the benefits of optimum-dosage reserpine.



**Renese<sup>®</sup>**  
(polythiazide)  
the longest-acting thiazide

**Renese-R<sup>®</sup>**  
(polythiazide 2 mg.  $\bar{c}$  reserpine 0.25 mg.)  
the longest-acting thiazide  
with reserpine

**Contraindications:** Polythiazide—Hypersensitivity to this or other sulfonamide derivatives. Advanced renal or hepatic failure. Reserpine—Mental depression, peptic ulcer or ulcerative colitis, and demonstrated hypersensitivity.

**Warnings:** Serum electrolyte determinations are especially indicated for patients with severe derangement of metabolic processes; e.g., surgery, vomiting, or parenteral fluid therapy. Patients with cirrhosis who are continually receiving Renese or Renese-R should be observed carefully for the development of hepatic precoma or coma. Indications of impending hepatic failure are tremor, confusion, drowsiness, and hepatic fetor. Thiazides may precipitate kidney failure and uremia in patients with pre-existing renal pathology and impaired renal function.

Available information tends to implicate enteric-coated potassium salts with or without thiazides in the etiology of nonspecific small bowel lesions consisting of ulceration with or without stenosis, causing obstruction, hemorrhage and perforation, and frequently requiring surgery. Deaths due to these complications have been reported. Enteric-coated potassium salts should be used only when adequate dietary supplementation is not practical and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs. Renese and Renese-R do not themselves contain enteric-coated potassium.

Electroshock therapy should not be given within one week of cessation of reserpine.

**Usage in Pregnancy and the Childbearing Age:** Since thiazides appear in breast milk, the usage of polythiazide is contraindicated in nursing mothers. Thiazides cross the placental barrier and appear in cord blood. The safety of reserpine for use during pregnancy or lactation has not been established. When polythiazide and reserpine are used in women of childbearing age, the potential benefits of this drug

combination should be weighed against the possible hazards to the fetus. The hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

**Precautions:** Polythiazide—Since all diuretic agents may reduce serum levels of sodium, chloride, and potassium, patients should be observed regularly for early signs of fluid or electrolyte imbalance (fatigue, muscle cramps, gastrointestinal disturbances, lethargy, oliguria and tachycardia). Unduly restricted salt intake or digitalis therapy may exaggerate effects of hypokalemia. Should hypokalemia occur or be suspected, foods high in potassium may be added to the diet (bananas, apricots, citrus fruits, prune juice, etc.) or oral potassium supplements administered if necessary. Consider lower dosages of Renese or Renese-R and other antihypertensive drugs when used concurrently. Like other thiazide diuretics, polythiazide may cause a rise in serum uric acid levels, disturb glucose tolerance even in previously normal patients or decrease PBI levels without signs of thyroid disturbance. Thiazide drugs may augment the paralyzing actions of tubocurarine, and may decrease the arterial responsiveness to norepinephrine. The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

Reserpine—Avoid or use cautiously in patients with a history of peptic ulcer or ulcerative colitis, patients with impaired renal function and in those receiving digitalis or quinidine. Extreme caution is needed in patients with a history of mental depression. If depressive symptoms, confusion or parkinsonism develop, discontinue use. Discontinue two weeks before elective surgery to avoid an unexpected

degree of bradycardia and hypotension. For emergency surgery, vagal blocking agents may be used to prevent or reverse hypotension and/or bradycardia. May cause increased appetite and weight gain.

**Adverse Reactions:** Polythiazide—With electrolyte imbalance: nausea, vertigo, weakness, paresthesias and fatigue. Most of these can be overcome by reducing the dose or taking measures to improve electrolyte imbalance. Maculopapular rash, reversible cholestatic jaundice, leukopenia, purpura (with or without thrombocytopenia), pancreatitis, photosensitivity, gastrointestinal disturbances, headache, xanthopsia, necrotizing angitis, orthostatic hypotension and dizziness have been reported. Agranulocytosis and aplastic anemia have been reported with the older thiazide diuretics, but not with polythiazide.

Reserpine—Hypersecretion, nausea and vomiting, anorexia, diarrhea, angina-like symptoms, arrhythmias (particularly when used concurrently with digitalis or quinidine), flushing of the skin, bradycardia, drowsiness, depression, nervousness, paradoxical anxiety, nightmares, parkinsonian syndrome, and C.N.S. sensitization manifested by deafness, glaucoma, uveitis, and optic atrophy have occurred. Nasal congestion is a frequent complaint, and pruritus, rash, dryness of mouth, dizziness, headache, purpura, impotence or decreased libido, and miosis have been reported with use of this drug. These reactions are usually reversible and disappear when the drug is discontinued.

**Supply:** Renese-R (2 mg. polythiazide—0.25 mg. reserpine)—blue, scored tablets. Bottles of 100 and 1,000.

Renese (polythiazide)—1 mg. white; 2 mg. yellow; 4 mg. white; scored tablets. Bottles of 100 and 1,000.

More detailed professional information available on request.

**Pfizer**

**LABORATORIES DIVISION**  
New York, N. Y. 10017

## Current Needs Of

# The Food Service Industry

BY G. E. LIVINGSTON, PH.D./NEW YORK

*I have been asked to depict the needs of the food service industry at this time. The needs are many, the problems numerous, the challenges extraordinary, but the opportunities for companies within the food service industry, as well as those in the food processing, packaging and equipment fields, which successfully apply themselves to the problems at hand, will lead to equally great rewards. What is needed is first a clear understanding of the nature of the problems, and second, a willingness on the part of interested businesses to make the necessary R & D commitments to develop the food products, packaging, equipment and systems needed by the food service industry as parts of the technology it requires to solve its problems.*



G. E. Livingston, Ph.D., is director, Food Science Program, Columbia University, New York; Consultant to the U.S. Public Health Service. Dr. Livingston is a member of the Institute of Food Technologists, the American Public Health Association, the Association for the Advancement of Science and the Royal Society for Health. Chairman of the Committee on Food Service Systems, National Academy of Science-National Research Council's Advisory Board on Military Personnel Supplies, he is scientific editor of *The Food Scientist*.

Before I share with you my thoughts about specific needs of the food service industry, I would like to describe the dimensions of the problem, and this I can, perhaps, do best by analogy.

Suppose you had a good sized, high quality, ladies fashion store. The clothes you sell are made in the back of the house. You have a temperamental designer, who is a creative genius but needs to be flattered, pampered and coaxed . . . and he happens to have several cloth manufacturers from whom he prefers to buy, though they may be more expensive than their competitors. If you suspect that some suppliers are showing their appreciation for your business by paying your designer's membership at a local country club and providing him with other niceties of life just ignore it, because this is not your greatest problem. Your most difficult task is to attract and hold good personnel. Salesladies come and go; they complain about the long working hours and your evening, Sunday and holiday store hours; they have no particular pride in their work because, basically, they resent waiting on customers and they are far more interested in the size of their commission than in the impression which they make on your customers. Among the people who do the sew-

*This paper was presented at the Symposium on Nutrition and Food Technology, Chicago, Feb. 12, 1969. This is the fourth in a series of five papers and is Contribution No. 5 from the Food Science Program of the Institute of Nutrition Sciences.*



ing and those who clean your machines and perform all the other necessary chores which the upkeep of an establishment such as yours requires, the turnover is greater still. Since some of these jobs are at the bottom of the ladder in terms of prestige and wages, they attract the most unstable individuals of all . . . people with various kinds of handicaps, physical or mental, and frequently language difficulties.

But tough as things may have been over the years, you did manage to show a profit. Now, things have begun to change rapidly. You are faced with a minimum wage which did not apply to you before. In theory it affected only the personnel at the bottom of the ladder, but in practice, it required you to raise wages at all levels to maintain proper differentials for various job classifications. Raw materials cost, which were rising slowly but steadily, could be offset by a slight increase in your prices, but the higher cost of labor can be compensated by increased prices in finished goods only at the risk of putting yourself out of business. Further, the labor pool for unskilled help is shrinking constantly and it becomes more difficult to get help at any price.

As if all this were not bad enough, you know that your designer is being courted by several of your competitors. While you pay him well, it is a safe bet that one of these days he will succumb to the offers of some high-powered chain or franchise operation. There is already a critical shortage of designers—the schools are not training enough, the European countries with their fine apprenticeship system, are now retaining their people at home—and you have no idea as to what you will do when your man goes.

If all this sounds a bit far fetched to you, it really is not. All you have to do, of course, is to change a few words here and there—replace “designer” by “chef,” “saleslady” by “waitress,” and “sewing machine operator” by “cook,” and you will have a profile of some of the problems afflicting the restaurant industry today. The fact that this story bears no relation to the clothing industry today is due to the fact that it adopted mass production techniques years ago. In combination with mass merchandising and distribution methods, the mass production of goods in factories which are remote from the point of sale

—frequently located where labor is cheapest, enables the consumer to purchase the goods she wants usually on a self-service basis, at a relatively low cost.

The fact that there is no parallel between the way other products are manufactured and distributed, be they clothing or automobiles, or in fact even preserved foods, and the way food products are manufactured and distributed in food service outlets is the crux of the whole problem!

That the food service industry is operating along antiquated lines and must change over by adopting as quickly as possible technological advances made in other fields, notably food technology, is generally accepted as the gospel today. What we need to define then are not the objectives, but the means, not the motives, but the methods.

First, however, let us look at some background facts. We are talking about an industry which in 1966 had 28 billion dollars worth of sales, purchased 34 billion pounds of food (20% of U.S. production), at a cost of \$12.7 billion and employed 3¼ million persons to prepare and serve 38 billion meals, in 591,485 establishments.\*

These figures of course are not new to you. They are, in fact, bandied about constantly to impress you with the size of this industry as a market. But what they fail to convey to you is that this is, in truth, a highly segmented industry. While all segments of food service have one fact in common, i.e., that they are feeding people away from home, each segment has its own peculiar problems and requirements. Feeding children in a school lunchroom is quite different from serving food at a variety store counter, which in turn is totally different from preparing food in a hotel kitchen. Food service through vending machines presents problems of stability and packaging which are not encountered in a hospital; while food service in an industrial cafeteria poses problems which are not relevant to an airline catering kitchen. This is one fact that is too often overlooked by new suppliers to the food service industry in designing their products.

Another fact which we should recognize is the low productivity of food service labor. (1966: \$11,628 annual sales per food

\*1969 total for number of establishments.

service worker, compared to \$45,798 annual sales for workers in grocery stores) Hence the greatest need of the industry is for products, equipment and systems which will increase worker productivity.

The old formula for controlling profit by holding down the percent food cost to a predetermined target, such as 40% or 45%, simply does not work any more. Now, it is the combined food and labor cost which must be controlled, if the profit targets are to be met.

If we admit then, that the changes which the food service industry must make at this point in time to increase productivity are to take place in the "back of the house," rather than in the "front of the house," the question of the adequacy of the complete meal, centrally manufactured and sent to the food service outlets for sale, warrants careful consideration. Clearly such a meal must be frozen, since of all conventional preservation methods it is the one in which the product most closely resembles the freshly prepared food. Why is it that the complete frozen meal as such has had so little success in food service? The reasons are several, but the basic one relates to the differing requirements of various segments of the industry. The choice of entrees and vegetables, the portion sizes, the method of cooking, the level of seasoning, the visual presentation will vary greatly from one type of operation to another and one geographical area to another. In general there is a desire on the part of food service operators for individuality in the presentation of food in their establishments. Short of preparing their own frozen foods—which is, of course, the present trend—it is difficult to see how this goal could be achieved. Individuality is not limited to the food but also applies to the plate. Assuming that nothing about the appearance or taste of the food would give it away as being a frozen meal, most operators would still be reluctant to allow a disposable plate to shatter the illusion that the food had been prepared on premise.

I certainly do not mean to imply, however, that frozen precooked platter meals are indistinguishable from freshly prepared, freshly plated out meals. No one has yet solved the problem of achieving separation of components of a meal similar to what is achieved with a compartmented tray, with-

out using such trays. So we must choose between a compartmented tray which is a dead give-away, or a meal in which an intermingling of juices and flavors occurs prior to freezing and upon reheating. If perchance the meal has to be held hot for any length of time before serving, even further intermingling of flavors occurs. In spite of freeze-thaw stable gravies and sauces, stabilized with gums or waxy starches, the gravy or sauce on a prepared meal rarely look as inviting as they would if they had been freshly poured.

We need to learn ways of improving upon this, and we need to find ways of minimizing traces of freezer burn which often accompany frozen storage of meals. We need to know more about the subtle slow storage changes which occur in frozen poultry and seafoods which result in adverse textural changes. And obviously we need disposables which do not look like disposables but are inexpensive enough to be used as throwaways.

Even if we solve all these problems, let us not assume that the food service market will suddenly gel as one great market for frozen dinners. It will still remain segmented, and hospitals, and schools, and cafeterias, and airlines, etc., will still continue to have their own requirements, which will have to be satisfactorily met on an individual market segment basis.

Serious as our problems may be in relation to entrees, at least we have a fair number of them in frozen form, and industry usage is growing. Two areas of food service remain great challenges to the ingenuity of the food technologist. One is salads, the other sandwiches. In considering the feasibility of total frozen systems, these two unfulfilled needs stand out as our main unsolved problems. I am not suggesting that we do not have any sandwiches or salad products in frozen or shelf stable forms. We do, but not enough and not the right kind. Until we can find a way of preserving for example, a club sandwich or a tossed green salad, in a way that will make them indistinguishable from the fresh article, we obviously have not solved the problem.

We also need more equipment which will enable us to thaw, and heat frozen foods quickly, uniformly and with maximum retention of eye appeal, flavor and nutritive value. Microwave ovens, infrared ovens,



steamers, and convection ovens all offer some useful features. Probably we will find that the answers lie in combinations of several heating modes, as exemplified in the Army's new SPEED kitchen.

Lest I convey to you the impression that all the problems of the food service industry can be solved via frozen foods, standardized packaging and better heating equipment, let me hasten to remind you that frozen foods are the most costly and difficult to transport and store and require the longest reheating. There is a need therefore for more high temperature-short time sterilized prepared canned foods, dehydrated foods, instant foods and freeze-dried foods. The goal in all cases must be to achieve a quality level which is as close as possible to the fresh food. This quality must be real quality, for a food service establishment's reputation and business are at stake every time a meal is served, not the reputation and the business of the processors who manufactured the foods used.

Neither do I wish to imply that we have reached the stage where prepared and processed foods can replace all fresh food preparation. Certainly, in large operations which are prepared to take meaningful steps in utilizing production equipment to reduce kitchen labor, much of the increased productivity needed can be achieved by using continuous preparation equipment. The Midshipmen's mess in Annapolis with its RAFT System is a good illustration of this type of modernization. Here, 4,000 meals are prepared in 30 minutes, with a maximum holding time of 45 minutes, and all 4,000 men are served in three minutes and out in 22.

What is needed, however, is food preparation equipment for such basic cooking steps as baking, broiling, frying, grilling, toasting, steaming and so on which is continuous and intermediate in capacity between the present batch-type equipment used in food serving operations and the plant size equipment used in the RAFT System. Continuous microwave ovens may also play a part in this area, particularly

if they could be combined with some other form of heating such as infrared broiling to cook and brown rapidly.

In considering the opportunities for applying existing technology to food service industry problems, we should not ignore the applications of computers to menu planning and cost control in mass feeding operations. Through linear programming techniques it has been proven possible to meet the need for dietary requirements and food preferences in hospitals while providing menus based on least expensive raw materials, resulting in food cost reductions in the order of 20%. If this can be achieved in hospitals where diet requirements are quite complex, it can surely be done in other areas of institutional mass feeding. Additionally, the benefits of computerizing ordering, storage control and even the scheduling of labor and kitchen operations are self evident.

Whether we use convenience foods or not, the approach to optimizing efficiency in food service operations must be based on a total system approach. I like to define a food service system as "an integrated program in which the procurement, storage, preparation and service of foods and beverages, and the equipment and methods required to accomplish these objectives, are fully coordinated for minimum labor and optimum customer satisfaction, quality and cost control." I am afraid that from the perspective of this definition which views a food service system as a totality, the word "system" as used by many companies and individuals today in relation to what I would consider to be product, packaging or equipment "sub-systems" has been greatly abused!

What the food service industry needs perhaps most of all then, are individuals who are capable by virtue of their training to carry out systems analyses and design original food service systems. This is an area in which a food technologist, with suitable training in engineering and an appreciation for food service, might well prove to be the most qualified individual! ◀

---

"The young leading the young is like the blind leading the blind."

Lord Chesterfield.

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**PRECAUTIONS:** Administer with caution to persons with known idiosyncrasy to atropine or cardiac disease. While under this therapy the urine is blue; patients should be so advised to allay apprehension.

**SIDE EFFECTS:** Neither irritation nor other untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occur, decrease dosage. If rapid pulse, dizziness, or blurring of vision occur, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

**CONTRAINDICATIONS:** Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

**DOSAGE:** Adults—Two tablets, orally, four times per day followed by liberal fluid intake. Acute cases—Initially two tablets every hour for three doses followed by the recommended daily administration. Children—One-half the adult dose.

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## NEW PHARMACEUTICAL SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturer's package insert or brochure.

**Single Chemicals:** Drugs not previously known, including new salts.

**Duplicate Single Products:** Drugs marketed by more than one manufacturer.

**Combination Products:** Drugs consisting of two or more active ingredients.

**New Dosage Forms:** Of a previously introduced product.

### SINGLE CHEMICALS

**MERUVAX**, Lyovac Biological Rx

**Manufacturer:** Merck Sharp & Dohme

**Nonproprietary Name:** Rubella virus vaccine, live

**Indications:** Immunization against German measles (check package insert)

**Contraindications:** Pregnancy; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; active febrile infection; patients with malignancies, or those receiving therapy with corticosteroids, irradiation, alkylating agents or antimetabolites; gamma globulin deficiencies.

**Dosage:** Single Dose, s.c.

**Supplied:** Single dose vial with disposable syringe.

### DUPLICATE PRODUCTS

**ASMATANE** Mist Bronchial Dilator o-t-c

**Manufacturer:** Riker Laboratories

**Nonproprietary Name:** Epinephrine bitartrate

**Indications:** Temporary relief of acute paroxysms of bronchial asthma.

**Contraindications:** None mentioned.

**Dosage:** One or two inhalations, p.r.n.

**Supplied:** Solution—0.3 mg./dose, in aerosol unit with oral adapter—10 cc.

**OPTIVAL** Eye Preparation Rx

**Manufacturer:** White Laboratories

**Nonproprietary Name:** Prednisolone sodium phosphate

**Indications:** Control of inflammation in acute allergic ocular disorders and traumatic injuries of the eye. Suppression of severe postoperative reactions following ophthalmic surgery.

**Contraindications:** Viral infections of the eye, active ocular tuberculosis, fungal infections, and untreated acute purulent infections of the cornea, lids and conjunctiva.

**Dosage:** During acute stage: 1 or 2 drops in conjunctival sac q.h. Maintenance: 1 or 2 drops q.3-4 h.

**Supplied:** Solution—0.5%, plastic dropper bottles of 5 cc.

(Continued on page 202)



## Meeting Memos

### Aug. 18-21—American Hospital Association

International Amphitheatre, Chicago

### Aug. 24-29—American Geriatrics Society

Sheraton-Park Hotel, Washington, D.C.

### Aug. 24—American Association of Nursing Home Physicians

Shoreham Hotel, Washington, D.C.

### Aug. 24—University of Kentucky, College of Medicine

*Symposium: Myotic Infections for the Clinician*  
Imperial House, Lexington, Ky.

### Sept. 4-6—American Association of Obstetricians & Gynecologists

*Annual Meeting*  
The Homestead, Hot Springs, Va.

### Sept. 5-7—Council on Clinical Cardiology of the American Heart Association

*10th Annual Cardiovascular Symposium*  
Williamsburg, Vir.

### Sept. 11-12—Utah State Medical Association

*Annual Scientific Meetings*  
Salt Lake City, Utah

### Sept. 12-17—Association of Medical Illustrators

Washington-Hilton Hotel, Washington, D.C.

### Sept. 14-18—Pennsylvania Medical Society

*Annual Meeting*  
Host Farm Resort Hotel  
Lancaster, Pennsylvania

### Sept. 14-20—College of American Pathologists

Palmer House, Chicago

### Sept. 15-16—AMA Dept. of Occupational Health

*Congress on Occupational Health*  
Stouffer Riverfront Inn, St. Louis, Mo.

### Sept. 16-20—Congress of Neurological Surgeons

Sheraton-Boston Hotel, Boston, Mass.

### Sept. 17-19—New York University School of Medicine

*Conception Control*  
New York University Medical Center  
550 First Ave. New York City, N.Y.

### Sept. 18-21—American Medical Writers Association

*Annual Meeting*  
Sheraton Hotel, Philadelphia, Pa.

### Sept. 19-20—Iowa Heart Association & Great Plains Heart Assn.

*Cardiovascular Symposium*  
Iowa Memorial Union, University of Iowa  
Iowa City, Iowa

### Sept. 21—American Society of Clinical Pathologists

Palmer House, Chicago

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SPECIALTY REVIEW COURSE IN MEDICINE, Part I, Sept. 15 & 19

SPECIALTY REVIEW COURSE IN SURGERY, Part I, October 20  
PATHOLOGY REVIEW COURSES FOR SPECIALTIES, Request Dates

PROCTOSCOPY & VARICOSE VEINS, One Week, September 9

ADVANCED HAND SURGERY, Three Days, September 9

SURGERY OF HEAD & NECK, One Week, September 15

SURGERY OF STOMACH & DUODENUM, One Week, Sept. 15

SURGERY OF COLON & RECTUM, One Week, October 13

ADVANCES IN SURGERY, One Week, August 25

VAGINAL APPROACH TO PELVIC SURGERY, One Week, Sept. 15

ADVANCES IN GYNECOLOGY & OBSTETRICS, One Week, Sept. 29

PEDIATRIC SURGERY, One Week, September 29

BASIC ELECTROCARDIOGRAPHY, One Week, October 6

DIAGNOSTIC RADIOLOGY, One Week, September 15

RADIOISOTOPES, One or Two Weeks, Request Dates

DERMATOLOGY, One Week, October 6

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## Quality of the Physician's Life

*(Continued from page 174)*

immersed. It is clear that leisure time must be allocated for the purpose of cultivation of what is truly human inside of us. The three aspects of this are keeping up with and contributing to scientific progress, contemplation of the humanities, and thoughts about the first principles of things. This time is considered necessary in addition to liberal amounts of loving interaction with friends and family, and a lack of it indicates a gap in the maturity of the individual. ◀

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## New Pharmaceutical Specialties

*(Continued from page 200)*

### VACCINIA IMMUNE

**GLOBULIN (Human)** Biological R

**Manufacturer:** Hyland Laboratories

**Nonproprietary Name:** Vaccinia Immune Globulin (Human)

**Indications:** Prevention or modification of smallpox by active-passive immunization, and of vaccinia infections by passive immunization. Treatment of complications of smallpox vaccination.

**Contraindications:** Active keratitis.

**Dosage:** Prophylaxis: 0.3 cc./kg. body wt., i.m., repeated 1 wk. later. Therapy: 0.6 cc. or more per kg. body wt., i.m., repeated at discretion of physician until recovery begins.

**Supplied:** Vials—5 cc., 16.5% sol.

### COMBINATION PRODUCTS

**OPTIMYD Eye Preparation** R

**Manufacturer:** White Laboratories

**Composition:** Each cc. contains:

Prednisolone sodium phosphate 5.5 mg.

Sulfacetamide sodium 100.0 mg.

**Indications:** Inflammatory and allergic conditions of the eye such as nonpurulent blepharitis and conjunctivitis.

**Contraindications:** Viral infections of the eye, active ocular tuberculosis, fungal infections, and untreated acute purulent infections of the cornea, lids and conjunctiva.

**Dosage:** During acute stage: 1 or 2 drops in conjunctival sac q.h. Maintenance: 1 or 2 drops q.3-4 h.

**Supplied:** Plastic dropper bottles—5 cc.

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472-9

## Systemic Disease— Splenic Rupture

(Continued from page 179)

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(Continued from page 142)

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## Work Week 56 Hours Long for Physicians

The results from 2,833 replies by physicians throughout the country to the first periodic survey of doctors conducted by the American Medical Association's department of survey research show that:

1. Office-oriented physicians practice an average of about 56 hours a week.
2. Of those 56 hours, more than 45 hours were devoted to direct care of patients.
3. Most doctors practice 48 weeks a year.
4. The average number of office visits was 95 per week.
5. Surgeons reported an average of 49 hospital visits per week, while general practitioners reported 35 visits.

## SALUD!

Some argue that beer is a health drink. They contend that if you drink one bottle a day for 1,200 consecutive months, you'll live to be 100 years old.

*Journal of the Mississippi State  
Medical Society*



# BLUE SHIELD REPORT



## FOR *Illinois Physicians*

PUBLISHED MONTHLY BY: BLUE SHIELD PLAN OF ILLINOIS MEDICAL SERVICE • 222 NORTH DEARBORN ST. • CHICAGO, ILLINOIS 60601

Vol. 3, No. 9

September, 1969

### Blue Shield Presents Films on Drug Abuse

The first of three documentary films presented by Blue Shield titled "A Movable Scene" and narrated by actor Robert Mitchum, focuses on drug abuse. The second film, "Flowers of Darkness", is narrated by Paul Newman. Academy award winner Rod Steiger narrates "Bridge From Noplace" the third and final film.

The documentaries are available to interested groups without charge and is another public service of Blue Shield. Each 20 minute color sound film is followed by an eight-minute interview by CBS-TV's director John Madigan. Mr. Madigan interviews three experts on the drug abuse situation in the metropolitan Chicago area.

Michael Finn, YMCA street worker, appears following "A Movable Scene"; Otto Heinecke, Regional Director of the Federal Bureau of Narcotics and Dangerous Drugs, discusses "Flowers of Darkness"; and Joseph Skom, M.D., Chairman of the Committee on Narcotics of the Illinois State Medical Society, discusses rehabilitation in the Chicago-land area, following "Bridge From Noplace".

The trilogy traces young drug users from San Francisco to the monasteries of Katmandu and back to the rehabilitation center in Lexington, Kentucky.

The documented series portrays the drug user as a disoriented individual in search of utopia.

"Flowers of Darkness", the second in the series, films the drug scene from the opium fields of Turkey to big city ghettos—the habitat of most drug users.

It shows the milky secretion of the opium poppy, its transformation into morphine and finally into heroin.

Heroin reduced to 5% with 95% milk sugar added is sold to the user for about five dollars. Thus, about 20 pounds of raw opium—sold by a Turkish farmer for approximately \$350 brings over \$400,000 to the narcotics dealer, and, in a panic, about \$500,000. "Flowers of Darkness" is filmed in Manhattan where personal interviews with heroin users were used in producing this outstanding series. The viewing audience hears a Bronx cab driver who discusses the drug problem in a sympathetic and realistic manner.



Rehabilitating the user of hard narcotics is the third and final film in the documentary series, "Bridge From Noplace."

There is no single bridge that will return the drug user to society.

Several treatment and rehabilitation centers are filmed showing a variety of techniques used to treat the patient.

Group therapy, for example, has proved an effective tool for aiding the addict and community centers located from coast to coast utilize self-help. Actual group therapy sessions are filmed in two well known rehabilitation centers—Synanon in Santa Monica, California, and New York's Daytop Village.

The series, filmed last year on locations around the world, was awarded a bronze medal in the Atlanta International Film Festival and has been submitted for the Lasker Science award. "A Movable Scene" was a finalist in the Chicago Film Festival.

In order to have these films scheduled at your meetings, send your request to Mr. Richard O'Connell, Director, Public Relations Department, Blue Cross and Blue Shield, 222 North Dearborn Street, Chicago, Illinois 60601.

*(This is not an advertisement)*

## ASK BLUE SHIELD

### • • • ABOUT MEDICARE

**Q** What procedure do I follow when submitting a claim for a Railroad retiree?

**A** Fill out an SSA Form 1490 "Request for Payment" in the usual manner and send it to Travelers Insurance Company, 175 W. Jackson Boulevard, Chicago, Illinois.

**Q** Can reimbursement be made for surgical dressings purchased by the patient when the physician has ordered the dressings and stated that they are medically necessary?

**A** Yes. Surgical dressings are covered under Medicare if they are required as the result of a surgical procedure performed by the physician. Surgical dressings are usually applied first by the physician but may be re-applied later by others, including the patient or family.

If the dressings are required due to reasons other than surgically created lesions such as bed sores, no reimbursement can be made.

**Q** Under what conditions can payment be made for whirlpool bath equipment used by a beneficiary in his home?

**A** In addition to the basic requirements for durable medical equipment, payment for installation and use of standard whirlpool bath equipment in the patient's home is limited to those cases where it is prescribed for conditions where the whirlpool bath can be expected to provide a substantial therapeutic benefit justifying its cost. For example, bursitis or chronic osteoarthritis would not generally justify Medicare payment for whirlpool bath equipment in the home. Moreover, when the patient is not homebound, payment for this item in the patient's home should be restricted to the cost of providing the service elsewhere, e.g., an outpatient department of a participating hospital, if that alternative is less costly.

In the rare case where home use of this equipment would comply with the above requirements, the physician's prescription must specify that he will be supervising its use in connection with his course of treatment. However, no payment can be made for a portable whirlpool pump for use in a domestic type bathtub because this item has not generally been accepted by the medical profession in the treatment of diseases or disorders.

**Q** I recently accepted assignment on a claim which was disallowed because the date of service was prior to the time the patient was entitled to Medicare. Now I cannot collect for his unpaid bill. What procedure do I follow to get this bill paid?

**A** The physician can follow the same procedure he follows to collect payment from his patients who are not covered by Medicare.

**Q** Is there a way to learn if the patient is entitled to Part B of Medicare without waiting for the claim to be processed?

**A** Yes. If your patient is entitled to Medical Insurance, his card will show two effective dates; one for his Medical Insurance and one for his Hospital Insurance.

**Q** Will Medicare make reimbursement for diagnostic testing performed by an Audiologist?

**A** Yes, if the testing is performed by a "qualified" Audiologist for the purpose of obtaining additional information necessary for evaluating the appropriate type of medical or surgical treatment of a hearing defect or a related medical problem. The diagnostic tests must be ordered by the physician. The tests would not be covered if they were primarily to determine the appropriate type of hearing aid or when the medical information required to determine the appropriate medical or surgical treatment is already known by the physician.

**Q** Please explain the proper way to submit a claim for a patient who is a Public Aid recipient and is also eligible for Medicare.

**A** Complete the SSA 1490 Request for Payment form in duplicate giving the beneficiary's Health Insurance Claim number in item #2 and Public Aid number in item #5. Submit one copy to the Medicare Carrier, and send the other copy to the Department of Public Aid, Springfield, Illinois 62706.

### Who Performed the Service?

A Medicare claim, whether you have or have not accepted an assignment, must indicate the name of the physician who personally provided the services. The SSA 1490 "Request for Payment" form can be pre-printed with the name and address of the physician who practices in the five county area of Cook, Kane, Lake, DuPage, and Will. Physicians in this area who do not use the pre-printed forms should indicate in item #8 of the SSA 1490 the full name and address of the physician who rendered the services listed.

Payments will be delayed when an itemized statement is submitted on letterhead listing more than one physician when the physician who provided the service is not identified. When this occurs, it is necessary for our Representatives to contact you or your office assistant by telephone or letter to obtain the information in order to make payment.

Therefore, to prevent unnecessary delays in payment, please indicate the name of the physician who provided the service on all letterhead bills listing the names of more than one physician as well as supplying the complete information on the SSA Request for Payment form 1490.



# Abstracts Of Board Actions

## Meeting June 28-29, 1969—Arlington Heights

*These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.*

### EXPANSION IN MEDICAL EDUCATION

ISMS President, Edward W. Cannady, requested that steps be taken to begin implementing the following recommendations from his Inaugural Address:

1. Expansion of internships and residencies, particularly in downstate areas—one new program each year by each medical school,
2. Acquisition of new funds to assist the medical schools in internship and residency expansion programs,
3. Formation of an independent Council on Continuing Medical Education, and
4. The establishment of an incentive program to encourage physicians to keep up to date through continuing education programs.

### STATE DEPARTMENT REPORTS

Dr. Franklin D. Yoder, Director, Illinois Department of Public Health, in reporting called for:

1. Further activity in solving the problems of health care delivery to economically strained areas,
2. Further attention to the need for more rehabilitation services, and
3. Further examination into what constitutes a nutritionally adequate diet for welfare recipients.

Dr. Henry Holle, Medical Director, IDPA, in reporting noted that IDPA was required by the Federal Government to do utilization reviews on all of its programs. Appreciation was expressed to ISMS for moving to activate a peer review mechanism. Dr. Holle noted that regardless of what happens at the Federal level with respect to fees, ISMS should understand that IDPA is attempting to do the best it can under the circumstances to pay reasonable fees.

### FINANCES

Acting upon the report of the Finance Committee the Board:

1. Approved a revised budget for the second half of the fiscal year,
2. Declined a request from AMA to share one-third of the \$22,000 cost of replacing a manikin at the Chicago Museum of Science and Industry—Chicago Medical Society likewise declined to participate,
3. Rejected a request from SAMA for supplemental budget funds to send representatives to the AMA meeting in New York and to pay living expenses of out-of-state SAMA chapter officers at a Regional Conference in Chicago in the fall of 1969.

## LISTING OF GOVERNMENT PROGRAMS

Compilation of a current list of Federal and State programs dealing with health for publication in one of ISMS' periodicals was approved as recommended by Dr. Willard Scrivner, 10th District Trustee.

## COMMITTEE APPOINTMENTS

Committee appointments as recommended by the Chairman of the Board were approved with minor modification. Members of the Board serve as consultants to Councils and Committees of their choice.

## DRUG FILM PUBLICITY

Approval was granted to publicize three motion pictures on drug abuse as recommended by the Committee on Narcotics. The films have been produced by the Arlie Foundation of Washington, D. C. and are being distributed by Blue Cross-Blue Shield. The Committee urged county medical societies to utilize these films for stimulating discussion of drug abuse problems in their communities.

## LEGAL COUNSEL OPINIONS

Legal Counsel advised the Board that the consent decree settlement of the Government's suit against the American College of Pathologists, has implications for ISMS. Among other things, there can be no interference with advertising by lay-controlled laboratories and they cannot be prevented from exhibiting at scientific meetings.

The Truth in Lending Act may apply to certain medical bills. This will be discussed in a forthcoming Journal article.

## IDPA ADVISORY COMMITTEE REPORT

A recommendation of the Committee that educational programs on foods and nutrition be established for welfare clients by IDPA was approved—also, an expansion of the food stamp program. These were suggested as solutions to the clamor over welfare food allowances. A recommendation of the Committee, that IDPA should pay physicians directly for their services in hospital out-patient departments, not through the hospitals, was approved.

## REVIEW SLATED FOR CONSTITUTION & BY-LAWS

The Constitution and By-Laws Committee was directed to review the entire Constitution and By-Laws with legal counsel to clear up numerous ambiguities which exist. A By-Laws change will also be drafted for presentation to the 1970 House of Delegates which would permit AMA delegates to serve as voting members of ISMS Councils and Committees.

## SAMA MEMBERS FOR COMMITTEE MEMBERSHIP

The SAMA Advisory Committee was directed to submit to the Board lists of students for positions on various committees of the Society in keeping with actions taken by the 1969 House of Delegates.

*(Abstracts Continued on page 280)*



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for unearthly cough*

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## ON THE COVER

A montage of newsclips in the shape of the President's Medallion brings out the point that the Illinois State Medical Society's President's Tour is being initiated. The first stop is September 17. In conjunction with ISMS President Cannady's Tour, Mrs. Sherman Arnold, President of the Woman's Auxiliary to the Illinois State Medical Society, will also hop-sotch the state meeting with all Auxiliary members. Mrs. Zelma Bechtol, President of the Illinois Medical Assistants Association will also join the entourage.

This is a significant event in Illinois medicine. In previous years the President's Tour has been one of the chief means of meeting the physician in his own back yard. Many important discussions were held and a definite insight into the views and needs of medicine was obtained. In 1969 the Tour has expanded.

District meetings are scheduled to be held in conjunction with Dr. Cannady's Tour. He will meet with county medical society officers, delegates and alternates in a give-and-take session. The District Trustee will take part in this program segment along with Dr. Cannady. A Public Affairs program will help all physicians and their wives gain knowledge about matters of politics and public affairs, such as con-con, the legislative process, what medicine must do in this field.

During the earlier events of the day the Woman's Auxiliary will hold a district meeting or workshop. A financial planning workshop for physicians and their wives promises to be of invaluable use. A concurrent session for medical assistants, hearing of office management and practices, will help the assistant to be better informed and more efficient.

All of these above programs are **free**.

Also in connection with the Tour, Dr.

Cannady will meet with local service organizations and the press to relate the needs of medicine and to recount activities in which ISMS is engaged to alleviate shortcomings of the health care system in Illinois.

Climaxing the day's activities will be a cash bar reception at 6 p.m., followed by the prestigious President's Dinner to which all attendees of the day are invited. Dr. Cannady will keynote and highlight answers to problems of medicine.

Many county societies are hosting these meetings in conjunction with their own activities. All members are encouraged to attend. If attendance at one district meeting is not possible, the welcome mat will be out at a neighboring district.

The scheduled meetings are:

**Sept. 17**—11th District; at Elmhurst Country Club, Wood Dale; Host—DuPage County Medical Society.

**Sept. 25**—2nd District; at Holiday Inn, Peru; Host—LaSalle County Medical Society.

**Oct. 9**—8th District; at Champaign Country Club; host—Champaign County Medical Society.

**Oct. 16**—6th District; at Holiday Inn, Quincy; Host—Adams County Medical Society.

**Oct. 22**—1st District; at Pheasant Run, St. Charles; Host—Kane County Medical Society.

**Oct. 30**—7th District; at Decatur City Club; Host—Macon County Medical Society.

**Nov. 6**—9th and 10th Districts; at Augustine's, Belleville; as part of Southern Illinois Medical Association Annual Meeting.

**March 26**—5th District; Host—Sangamon County Medical Society.

**April 16**—4th District; at Pere Marquette Hotel; Host—Peoria County Medical Society.

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## Turn Off the Negative

"We must not let ourselves come to think of our communities as a mass of failure. This would undermine the forward drive of all who are working toward improvement."—Arch N. Booth, Executive Vice President, Chamber of Commerce of the United States.





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Edward W. Cannady, M.D.

# The President's Page

## Fee Moderation Is Essential

"You don't have to look far when you speak of the Mafia," exploded an irate housewife in a letter to her congressman, "the greatest thieves in this country are the doctors."

The woman's letter, which eventually found its way to the ISMS Ethical Relations Committee, reflects a seething resentment toward the medical profession that is devastating to our public image. Reinforced by biased or unbalanced coverage in the mass media, the public's general discontent poses a serious threat to the doctor-patient relationship, a pact built upon mutual trust and respect.

Although the sentiments of the angered housewife may be a bit extreme, they pinpoint the basic factor that has led to this unhappy confrontation—money. The majority of our patients are not questioning the doctor's expertise, but why, as one patient said, "you charge so damn much for it."

Indeed the prestige of the medical profession in terms of its accomplishments has never been greater. And most patients can accept the fact that better care naturally costs more money. As Vermont C. Royster, editor of the *Wall St. Journal* noted recently, "One reason medical care was cheaper in the olden days is that there wasn't so much that could be done."

Unfortunately quality is an intangible factor, the benefits of which are not always easily demonstrated and justified to the patient. Increased quality does not readily explain why the charge for a tonsillectomy has gone up 70% since 1955, nor why the price of an appendectomy has increased 55%, according to the Health Insurance Association of America.

We must be ready to talk with our patients in concrete terms about why medical costs have risen. A few extra minutes of explanation may make the difference between a patient who pays the bill and one who refuses. In this regard, a recent study by a Michigan practice management firm indicated that their clients' collection percentages are dropping and that an "I don't want to pay" attitude may be mounting.

In explaining our fees to patients, most of us can point to rising operating expenses as the greatest contributor to rising fees. Upon examining some of our office's operating costs recently, I noted that total expenditures have risen steadily since 1955, although the number of physicians in the office has remained constant. Biggest increases were in insurance, up nearly 700%; office salaries, up 100%; medical supplies, up 100%; and postage up 180%.

All told, our operating costs have increased 77% since 1955, which I believe is adequate justification for the \$1 increase in office visit fees that we made in 1966—an increase of only 20%.

Naturally, I do not rule out the possibility of further fee increases. Unless inflation is somehow curbed, it will be inevitable. And I think most patients will accept this, realizing that doctors are no more immune to inflation than they are.

Yet, as we contemplate future fee increases we must consider all other means of bringing in the necessary extra dollars. Increasing our productivity may be one solution. The experts estimate that an increase of little more than 7% in the patient-visit rate can, in most cases, raise net earnings 10%.

*(Continued on page 308)*



# Pitfalls in the Diagnosis of Subclavian Steal

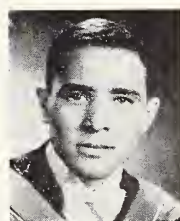
BY MARVIN B. WEBER, M.D., F.R.C.P. (C.)/WILLOWDALE, ONTARIO, CANADA

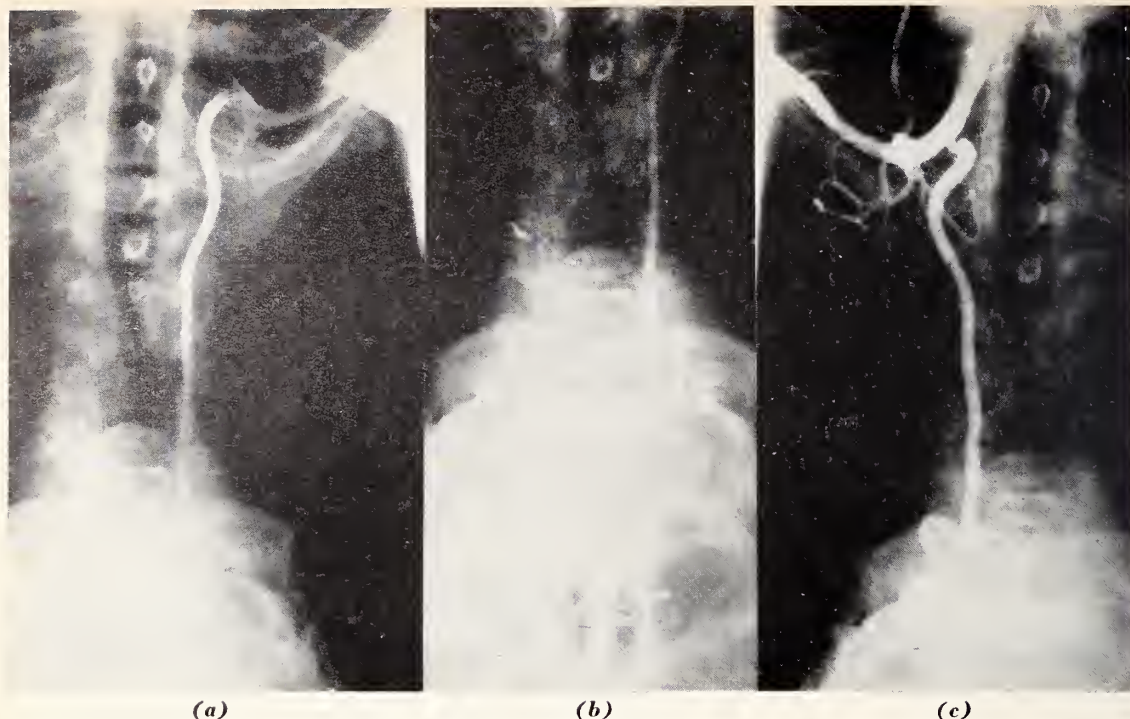
*The focus of attention in "subclavian steal" has been placed on the proximal subclavian artery.<sup>8</sup> Although innominate artery occlusion has been recognized as a cause of retrograde flow in the right vertebral artery,<sup>3</sup> a recent review of the subclavian steal syndrome<sup>8</sup> revealed that only 10 of the 110 reported cases were due to innominate occlusion. The case reported here had unusual radiological features. In addition to 75% innominate stenosis at its origin, there was an apparent stenosis in the proximal right subclavian artery. Which lesion was responsible for the patient's subclavian steal? This question and the arguments called forth in support of one lesion or the other, prompted this report.*

## CASE REPORT:

For three years prior to admission to hospital Mr. C.W., a 59-year-old male, had been subject to dizzy spells which were not vertiginous in nature. The dizziness consisted of a feeling of uncertainty or unsteadiness, but had never actually forced the patient to stagger. Attacks lasted seconds, or all day, and free periods were as long as weeks or months. Additionally, he had had occasional paraesthesiae of the dorsal aspect of the right forearm. At times

Marvin B. Weber, M.D., is a Canadian neurologist. He received his M.D. degree from the University of Toronto and served his residency in neurology at Barnes Hospital, St. Louis, Mo. A Fellow of the Royal College of Physicians of Canada, Dr. Weber also serves as a consultant to the Alton State Hospital, Alton, Illinois.





(a)

(b)

(c)

**Fig. 1.** Left retrograde brachial arteriogram: (a) stenosis of origin of left vertebral artery, (b) retrograde flow in right vertebral artery, (c) opacification of distal right subclavian artery.

he felt as if the "power was drawn out of his right arm," but the arm had never proven weak when put to the test.

Unassociated with the above, the patient had noted 10-15 episodes of blurred vision and diplopia. These episodes lasted two to three minutes and could be relieved by covering one eye. Attacks of diplopia had occurred in clusters with long intervals (months) between episodes.

The patient had been well otherwise except for aching pains in his neck and low back referable to ankylosing spondylitis from which he had suffered for 20 years. In the past, this had been treated with 600 roentgens of X-rays directed to the cervical and upper dorsal spine.

On physical examination the right radial pulse was considerably weaker than the left. The blood pressure was 100/80 in the right arm and 150/80 in the left arm. The right carotid pulse was diminished and there was a thrill over this artery. A bruit was heard over the right carotid artery and in the right supraclavicular fossa. Deep tendon reflexes were increased in the left arm and leg. The patient was asked to exercise his right arm on several occasions and once this precipitated a "dizzy spell" identical to those he had experienced in the past. A similar episode was elicited immediately after compression of the left car-

otid artery. Ophthalmodynamometry revealed a pressure of 90/40 mm Hg. in the right eye and 130/50 in the left.

### Angiographic Findings

A left vertebral angiogram by retrograde left brachial injection (Fig. 1.) showed 50% stenosis of the left vertebral artery at its origin. There was retrograde filling of the right vertebral artery and late opacification of the distal right subclavian artery. There was no opacification of the proximal right subclavian artery.

A right retrograde brachial injection (Fig. 2) filled the cervical part of the right vertebral, the proximal right subclavian, the innominate and right common carotid arteries but the proximal right subclavian, the innominate and right common carotid arteries were poorly opacified. No intracranial arterial stenoses were demonstrated.

An aortic arch injection via femoral catheter (Fig. 3) showed 75% narrowing of the origin of the innominate artery. A filling defect was seen over the superomedial aspect of the right subclavian artery just proximal to the origin of the right vertebral artery. There was no anterograde filling of the right vertebral, but this artery filled three to four seconds later from above.

A percutaneous left carotid arteriogram was normal.



## Discussion

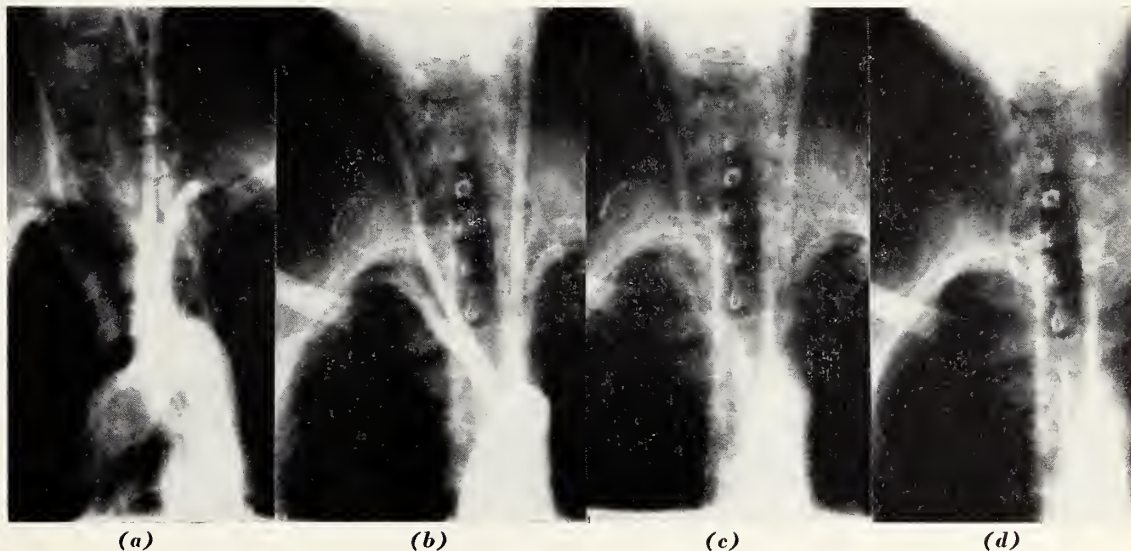
The retrograde flow of blood in the right vertebral artery by definition establishes this case as one of subclavian steal.<sup>1,9</sup> It is recognized that retrograde flow in the vertebral artery may occur in the absence of any innominate or proximal subclavian occlusion and its presence is frequently unassociated with any neurological symptoms.<sup>6,7</sup> Although "dizziness" that is not vertigo has been reported in 55% of patients with subclavian steal,<sup>8</sup> the symptom is not necessarily a consequence of basilar insufficiency. However, on the basis of the episodes of diplopia, it is reasonable to assume that the subclavian steal was producing symptomatic and clinically significant basilar insufficiency.

The radiological features tended to incriminate a lesion in the proximal right subclavian artery as the critical lesion rather than the innominate for the following reasons: Retrograde flow in the right vertebral artery progressed only to the distal subclavian artery (Fig. 1) but there was no opacification of the proximal subclavian or right common carotid arteries. Were the innominate lesion critical, resultant low pressure in the proximal subclavian and right common carotid arteries should have allowed vertebral blood to flow proximally as well as distally. Additionally, the "lesion" in the proximal right subclavian artery (Fig. 3) is well situated to produce a



**Fig. 2.** Right retrograde brachial arteriogram: the proximal subclavian, innominate and common carotid arteries on the right are poorly opacified.

Venturi effect.<sup>10</sup> Bernoulli's theorem dictates that laminar flow in a non-distensible



**Fig. 3.** Aortic arch arteriogram via femoral catheter, (a) stenosis of origin of innominate artery, (b) filling defect over superomedial aspect of right subclavian artery, (c) no anterograde filling of right vertebral artery at 1½ secs. (d) retrograde filling of right vertebral artery at 3½ secs.

tube will increase in velocity but decrease in pressure at the site of a narrowed portion of that tube.<sup>10</sup> By this mechanism, a small decrease in pressure localized to the mouth of the right vertebral artery would be sufficient to effect retrograde flow in that artery.<sup>9</sup>

Features incriminating the innominate stenosis as the critical lesion appeared to have lesser weight: the stenotic lesion occluded 75% of the diameter of the vessel. This degree of narrowing approaches but does not meet the criteria of Brice et al<sup>4</sup> of a stenosis sufficient to reduce blood flow significantly. (The clinical finding of a decreased right carotid pulse and the ophthalmodynamometry data, however, indicated the innominate stenosis had some significance.) Additionally, the right retrograde brachial injection failed to demonstrate the filling defect in the proximal subclavian as seen in the aortic arch study.

Management of the case required evaluating both the clinical and radiological features and the relative risks of two possible surgical approaches. Endarterectomy of the proximal right subclavian is a relatively benign procedure.<sup>5</sup> Repair of an innominate lesion is more formidable and requires temporary clamping of the carotid artery, introducing risk of serious morbidity and mortality. Endarterectomy of the proximal right subclavian artery was the decided course.

At surgery, the proximal right subclavian artery was explored by arterotomy. No lesion was found. The vessel was entirely normal throughout its proximal segment. The filling defect seen on the arteriograms may have been a flow artefact.

Although it was now evident that the cause of the steal was the innominate stenosis, the patient's symptoms were not severe enough to justify the surgical risk involved in innominate artery repair. Moreover, as Berger et al<sup>2</sup> have recently pointed out, repair of the innominate artery stenosis may sufficiently increase pressure in the right vertebral artery so that the pressure at the vertebralbasilar junction may then exceed that in the proximal left vertebral artery. Low pressure in the proximal left vertebral artery in the case reported here is likely a result of the stenotic lesion at the origin of the left vertebral artery (Fig. 1). Repair of the innominate stenosis would increase pressure in the right vertebral ar-

tery and vertebral-basilar junction effecting retrograde flow down the left vertebral artery as blood flows from a region of high pressure to a region of low pressure. Further surgery might then be required to open up the left vertebral artery and correct the iatrogenic left subclavian steal.

## Summary

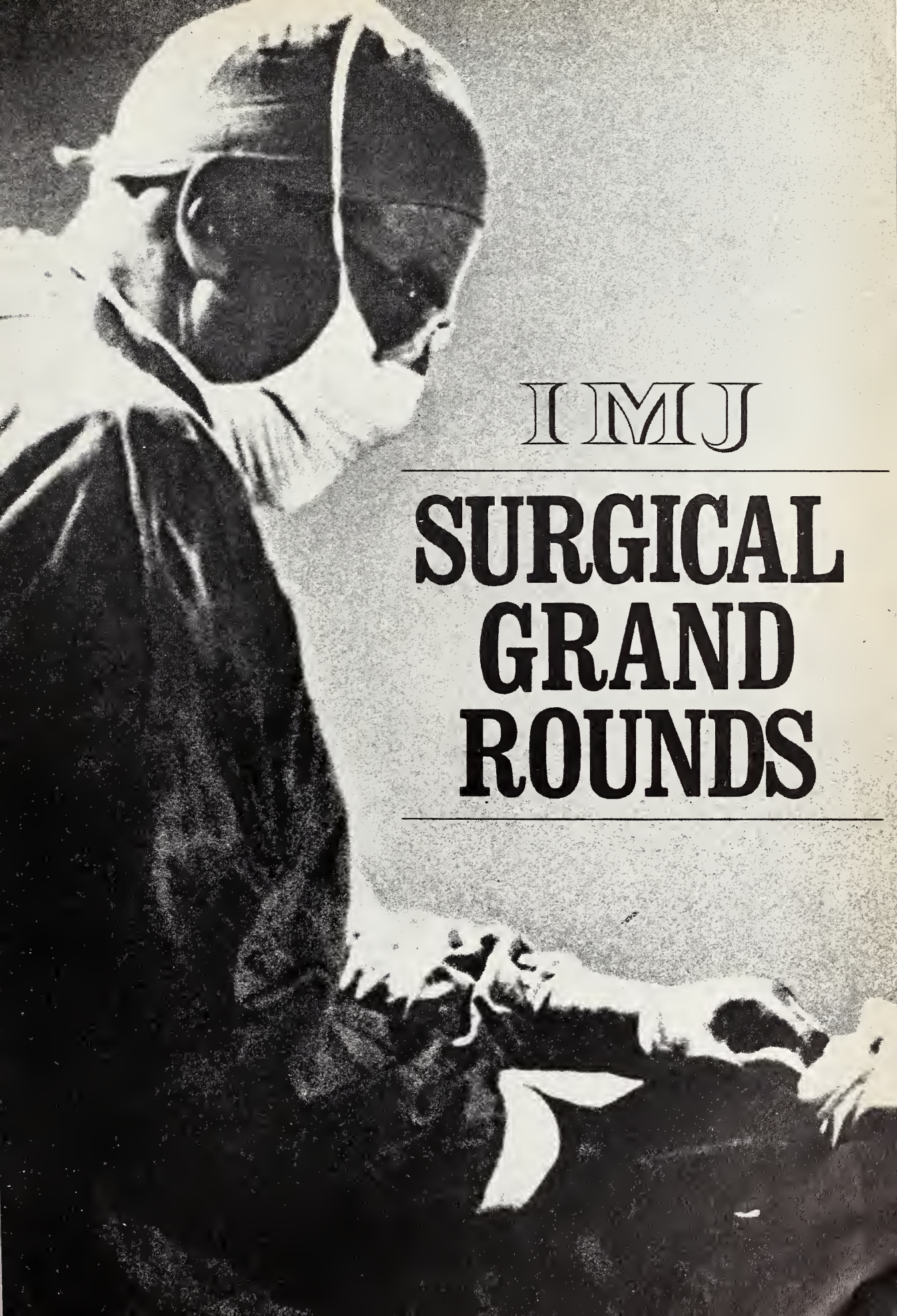
A case of subclavian steal with symptoms of basilar insufficiency is presented. Angiography showed stenotic lesions in the innominate, the left vertebral and proximal right subclavian arteries. The latter lesion appeared to be the critical one causing the steal. However, no lesion was demonstrated at exploration of the right subclavian artery.

Although it became evident that innominate stenosis was the causative lesion, surgical repair was not carried out in view of the surgical risks which include the recently recognized iatrogenic subclavian steal.<sup>2</sup> ◀

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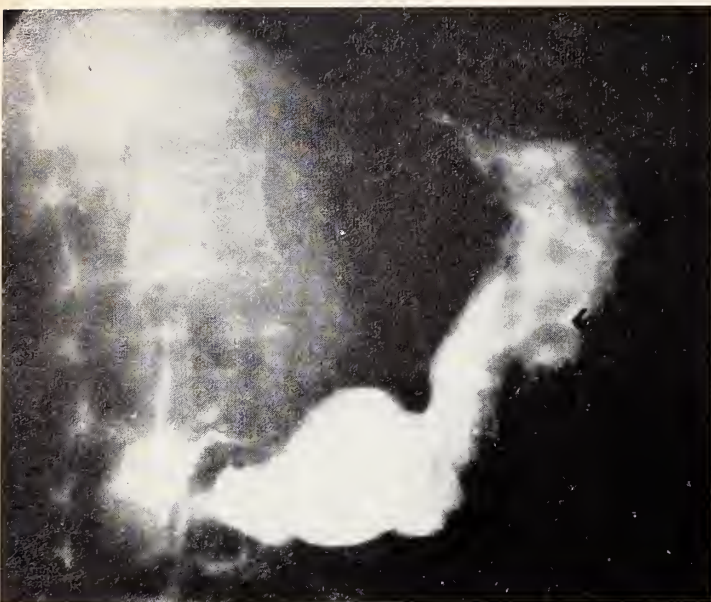
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# **SURGICAL GRAND ROUNDS**

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**Fig. 1** Roentgenogram of the stomach shows "cobblestone" appearance, particularly along greater curvature.

# Gastric Polyposis

EDITED BY JOHN M. BEAL, M.D./CHICAGO

*Surgical Grand Rounds are held weekly on Saturday at 8:00 a.m.; alternating between the Staff Room, Chicago Wesley Memorial Hospital; and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds held at Passavant Memorial Hospital on March 8, 1969.*

## Case Presentation

**Dr. Charles McHugh:** A 62-year-old taxi driver entered the Veterans Administration Research Hospital complaining of progressively increasing midepigastric dull pain of six weeks duration. The pain radiated to his back and was not related to the intake of food or to activity. He reported intermittent eructations and mild distension but denied nausea, vomiting, anorexia, change in bowel habits or melena. Approximately 12 years ago he was studied at another hospital for "stomach trouble" but was not given a specific diagnosis. A bland, low fat diet was prescribed which he followed fairly well. However, he has maintained a moderate alcoholic intake daily. In 1964, he was found to have carcinoma of the soft palate, which was treated with irradiation without evidence of recurrence to date. His residual disability is mild hoarseness. When examined, blood pressure, pulse and temperature were normal. The physical examination was within the normal limits except for his hoarseness, skin changes over the anterior larynx and mild epigastric tenderness. Blood count and urinalysis were within normal limits. The 12 hour overnight gastric aspiration yielded the volume of 200 ml, pH of 6.97 and free acid was absent in the aspirate. X-ray studies were performed. The pertinent findings were limited to the upper gastrointestinal tract.

**Dr. Michael Murphy:** At fluoroscopy the greater curvature of the stomach appeared rigid and did not have normal peristaltic motility. Films show an apparent intrinsic filling defect in this area. The mucosal pattern has a "cobblestone" appearance on some films (Fig. 1). Multiple small circular defects are seen on spot films (Fig. 2). Although this "cobblestone" pattern is known to occur in polyposis, Menetrier's disease and hypertrophic gastritis, our primary diagnosis was malignancy involving the greater curvature of the stomach because of the marked rigidity seen fluoroscopically. This patient, incidentally, had a normal appearing chest film.

**Dr. McHugh:** On February 20, the patient was taken to the operating room. Upon opening the abdomen, the stomach had a normal external appearance. Careful palpation suggested the presence of a polyp



in the antrum. A gastrotomy was performed and examination of the mucosa revealed marked polyposis occupying most of the antrum (Fig. 3). Therefore, approximately 60% gastric resection was undertaken with a Billroth I reconstruction.

**Dr. Joseph Sherrick:** Microscopically, one sees striking hypertrophy of the rugae in a polypoid arrangement (Fig. 4). The marked thickening of the rugae is due to proliferating glands. The glandular elements are distorted and the usual regular arrangement of the epithelium is no longer apparent. There is some thickening of the sub-mucosa with increase in vessels and fibrosis. These changes are consistent with adenomatous hyperplasia of the gastric mucosa. It does have a polypoid appearance, and thus the diagnosis of gastric polyposis is justified.

**Dr. Scheidt:** The preoperative diagnosis was carcinoma of the stomach, and the normal appearance of the stomach was surprising. However, the polyps were detected by palpation and a partial gastrectomy was performed.

The first identification of gastric polyps was by Giovanni Battiste Morgagni at the University of Padua. He was the first of the great correlators of clinical and autopsy finding and was the chief precursor of Virchow in pathologic anatomy. He identified gastric polyps at the time of an autopsy in 1769. The first clinical diagnosis of a gastric polyp was by Sir Richard Quain, an English medical lexicographer. He had a young female patient who suffered repeated episodes of vomiting. Finally she vomited a piece of tissue which was a gastric polyp and was cured. Thus, the first cure was effected by non-surgical means. The X-ray diagnosis was first made in 1912 and the first gastroscopic diagnosis in 1922.

A satisfactory descriptive definition of a polyp is any lesion in the intestinal tract which can be manipulated or rotated 90 degrees without putting traction on the surrounding mucosa. If the polyp is broad-based and cannot be thus manipulated, then one should prefix the word sessile. "Polyp" is a gross description term and not a microscopic definition, thus having nothing to do with diagnosis and prognosis. Our specimen qualifies well for a gross diagnosis of gastric polyposis.

In most reviews gastric polyposis is stated to occur in approximately 0.43% of all pa-

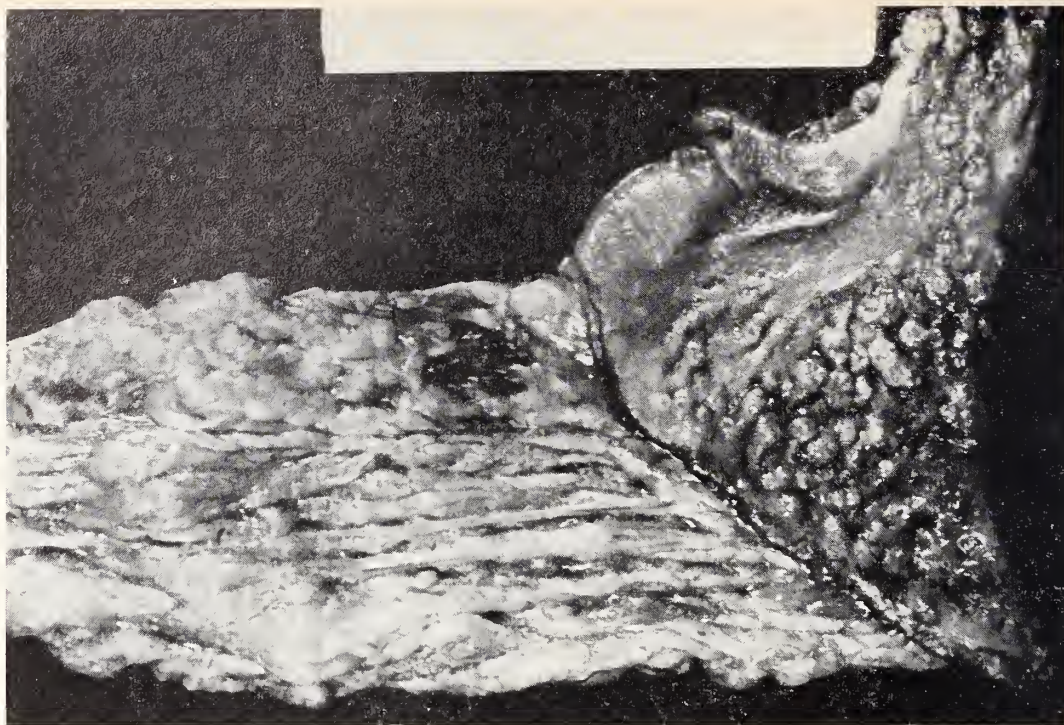


**Fig. 2** Spot films of greater curvature demonstrate multiple small circular defects.

tients, or about one in 200. It has been said to be associated with a 10% incidence of malignancy. The diagnosis is made by radiologic study and by gastroscopy. Patients with gastric polyposis usually have vague symptoms, much as this man had. Epigastric pain and vague symptoms of fullness are common. Occult blood may be detected in the stools and, less commonly, hematemesis may occur. Vomiting may occur when polyps prolapse through the pylorus and obstruct. There is a 95% incidence of achlorhydria. Approximately 10 to 15% of patients with gastric polyps have pernicious anemia. The peak incidence of this disease is in the seventh decade.

The most important question about gastric polyps is the relation to gastric malignancy and whether the gastric polyp is a pre-malignant lesion. Dr. Sherrick pointed out that there was rugal hypertrophy, achlorhydria and evidence that the stomach was old and atrophic. These polyps may be related to these changes.

In a review of this problem, one must mention polyposis in general. This controversy was brought into sharp focus by Spratt, Ackerman and Moyer in *Annals of Surgery* 1958. They denied that intestinal polyposis was pre-malignant. They based this statement on three observations: (1) Carcinoma in-situ does not metastasize. (2) The pattern of distribution of carcinoma of the large intestine does not follow the pattern of polyps. (3) If two polyps each had an equal chance of becoming malignant, as many carcinomas would be found in the colon with polyps distal to them as polyps proximal to them. These authors observed that carcinomas in the ascending colon had more polyps distal to them than would occur randomly, and that carcinomas in the distal portion of the colon had more polyps



**Fig. 3** Specimen of portion of stomach removed shows multiple polyps. General portion of omentum extends to left.

proximal to them. They concluded that cancer was developing *de novo* in the mucosa of the intestine. In 1958, Drs. Castleman and Krickstein of Massachusetts General Hospital reviewed 322 intestinal polyps, which had been previously reported, to demonstrate that these polyps gave rise to malignancy. They concluded that the villous adenoma may give rise to carcinoma but the overwhelming majority of carcinomas arise *de novo*.

In 1962, Castleman, Monaco, Roth and Welsh published information on 153 patients with gastric polyps. They came to the conclusion that, although there was 10% atypia, polyps under 2 cm in diameter were unlikely to be malignant and did not require removal.

A recent paper from the University of Pennsylvania appeared in the *American Journal of Surgery*, May, 1966. A 10 year review reported 35 gastric polyps and eight were malignant. It was found that of these eight malignant polyps four were less than 2 cm in diameter. There is also a report from Mt. Sinai Hospital in Cleveland where three gastric polyps were seen at the time of gastroscopy. Two years later two of these polyps were the same but the third was malignant.

The treatment of gastric polyps has also been controversial. Welch of Massachusetts General Hospital suggests that one should

divide them into three categories: 1) The single discrete polyp, which should be operated on only when it is more than 2 cm in size and the patient is symptomatic. 2) Localized polyposis (as in the present patient) where operation is indicated only if there are polyps greater than 2 cm in size or if the patient is symptomatic. 3) Generalized polyposis of the stomach in which case the patient should have a total gastrectomy. Interestingly, there are few patients without symptoms, so one might conclude that if one of the criteria for surgery is symptoms, almost all of them would come to surgery.

**Dr. T. Howard Clarke:** I should like to describe a patient that emphasizes the relationship of gastric polyposis and carcinoma of the stomach. The patient was 60-years-old in 1956, when films were made showing a situation almost identical with the one presented today. A sleeve resection of the mid-portion of his stomach was performed. The pathologist reported benign polyposis of the stomach.

There was no sign of disease in the portion of stomach that was left. Subsequent X-ray studies appeared to be normal and the patient remained in good health for approximately 4 years. He then became anemic, occasionally vomited blood and required transfusions. Gastrointestinal radiographs in Florida where he was working





**Fig. 4** Photomicrograph through one of the polyps shows proliferating glands but absence of malignant change.

were reported normal in May, 1961. Studies at Chicago Wesley Memorial Hospital also were reported normal and he returned to Florida where he again experienced severe bleeding and required transfusion. Re-examination in November, 1961, was reported normal. In February, 1962, he returned to Chicago and films at that time showed a defect in the cardia adjacent to the esophagus that was interpreted as carcinoma. This diagnosis was confirmed at the operating table and a total gastrectomy was performed.

The question that comes to mind, of course, is whether a more radical operation is justified when gastric polyposis is first diagnosed. Should one do a total gastrectomy with its attendant high mortality and severe disability for a benign but cancer-related disease? I think not. The anticipated benefit to the group is out-weighted by catastrophic sequelae for a significant number of patients. Should one do a more extensive resection, let us assume a 75-90% resection, hoping to remove most of the potentially cancer-producing portion of the stomach? There is some merit in this suggestion. But then should it be a proximal or distal resection? Certainly a distal resection would have left our patient with the very area that later bore the cancer.

I expect Doctor Scheidt performed the proper operation on his patient. I also expect our first operation was correct. Our difficulty stemmed from two considerations:

(1) The great difficulty of examining the high gastric remnant—a situation somewhat improved in recent years with cine-fluoroscopy and with more versatile gastroscopes.

(2) Our patient was very busy in a large business enterprise, bled intermittently, and appeared to be well in the intervals between bleeding episodes. He just didn't have time to be operated upon nor could we tell him that the operation was urgent and imperative.

I would certainly agree that resection of the apparently diseased segment should be sufficient, that the patient should be re-examined at frequent intervals, and that he should be subjected to reexploration at the first suspicion of further disease in the stomach. ◀

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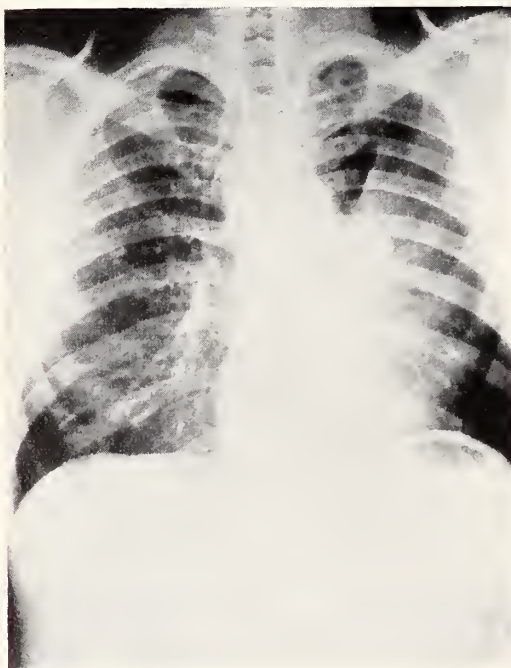


## THE VIEW BOX

BY LEON LOVE, M.D.

*Director, Department of Diagnostic Radiology, Cook County Hospital,  
and Clinical Professor of Radiology, Chicago Medical School*

This 54-year-old man entered with a one week history of cough, with slight hemoptysis. He had a previous history of smoking  $2\frac{1}{2}$  packs of cigarettes per day for 20 years. What is your diagnosis?



**Fig. 1**

- 1) Pneumonia
- 2) Pulmonary Embolus
- 3) Carcinoma of the left upper lobe with complete atelectasis of the lobe.
- 4) Tuberculosis



**Fig. 2**

*(Answer on page 305)*



# Group Practice in the Education Of Medical Students

BY LEON O. JACOBSON, M.D. AND RICHARD L. LANDAU, M.D./CHICAGO

The University of Chicago Hospitals and Clinics were established approximately 41 years ago. From the start, this was an experiment in the development of a wholly full-time medical faculty operating in hospitals and out-patient clinics owned and operated by and on the main campus of the university. Although it has evolved operationally as changes in medicine, society, and finances have dictated, the principle of the full-time university faculty as the sole clinical staff has prevailed.

## Early History

When the institution opened its doors in 1927, endowment income was sufficient to keep charges to patients at a level considerably less than cost, as was the style for teaching hospitals of that day. From the first day, The University of Chicago Clinics attracted patients who could well afford to make a choice of physicians. These patients chose the Clinics not merely because of the reasonable fees, but because of their confidence that The University of Chicago would provide a faculty of highly competent physicians and surgeons.

*This paper was presented by Leon O. Jacobson, M.D., at the meeting of the New York Academy of Medicine Conference on Group Practice.*

The transition of this medical school operation of hospitals and clinics from the largely free service operation originally conceived to one that was largely fee-for-service was essentially an historical accident. The great depression of the late twenties and thirties coincided more or less with the institution of the program. The resultant reduction in endowment income, foundation support, and private gifts meant that the University must develop an in- and out-patient fee-for-service schedule that would be consistent with operational cost. By approximately 1952, the entire out-patient operation had become financially self-sufficient, and from that time on has actually produced a net professional fee



Leon O. Jacobson, M.D., is the Dean of the Division of Biological Sciences and the Pritzker School of Medicine at the University of Chicago. He also is the Joseph Regenstein Professor of Biological and Medical Sciences at the University. Richard L. Landau, M.D., (not pictured) is a

Professor of Medicine at the University of Chicago, Pritzker School of Medicine and Director of its Clinical Research Center.

income approximating \$2 per visit. At about the same time, the in-patient operation also became self-supporting. Approximately 10% free or partially paid beds were available by virtue of endowment, gifts, and public medical aid programs; the remaining 90% were fully paid for by the patients or third-party insurance carriers. Professional fee income for in-patient service was charged to paying patients in the name of the admitting or attending physician. The prerogative of setting individual patient fees has always remained in the individual physician's hands. The available free service has provided a mechanism for the hospitalization or out-patient visits of unique clinical material vital to teaching and research programs.

An additional 54-bed research facility was added to the campus medical center by the construction of the Argonne Cancer Research Hospital, a unique facility financed by the Atomic Energy Commission and operated by The University of Chicago, which opened its doors in 1951. A 29-bed clinical research center financed by the U. S. Public Health Service was added in 1961. Thus, The University of Chicago has built and operated what is essentially a huge group practice with out-patient facilities handling total yearly visits of 175,000; an emergency room of 35,000 visits per year; and a hospital of 700 beds with little cost to the endowment income of the University save for funds specifically given for this purpose. In addition, the small yearly surplus income from the out-patient clinics, with professional fees collected from, or on behalf of, hospitalized patients, have been used to support the salaries of the faculty of the school of medicine of The University of Chicago.

### The Faculty

The initial clinical faculty was recruited to study, investigate, and teach on the same full-time basis as professors on other faculties of the University of Chicago. The only obvious distinction was that the clinical faculty also was expected to care for patients, an activity closely and of necessity bound to scholarly effort. This clinical effort has had no real bearing on faculty salary level. Salaries are, of course, competitive with those of other medical schools, but relatively speaking have been

based exclusively upon academic performance of individual faculty members. Philosophically, the out-patient clinics and the hospital rooms and related facilities are the laboratories maintained by the University in order that the clinical staff may fulfill its teaching and research obligations. No apology need be offered for the fact that this laboratory is essentially self-supporting. Indeed, this *philosophy*, including the collection of fees, was recognized if not fostered by an agreement between The University of Chicago and the Chicago Medical Society in 1928. The very fact that there was a fee-for-service determined that the clientele would largely originate from the middle class, and so it has continued until recent years, when Medicare and other federal legislation began to provide payment for clinic and hospital care for the lower-income group of citizens. At the present time, several of our clinical departments are involved in medical care clinics in the ghetto. A valid criticism of our teaching program in the past may have been that our faculty, medical students, and house officers were not proportionately exposed to the medical and social problems of the lower-income groups. Our full-time group practice medical school operation lends itself to cautious experimental involvement in these problems, but our commitment must be approached with the fact always clearly in mind that our primary objective is that of teaching medical students, providing post-M.D. training, and carrying on a scholarly program in the life sciences. The service and community responsibility must of necessity remain a secondary objective.

The clinical faculty which began as a relatively large group practice has grown through the years to an even larger co-operative clinical organization. At the present time, the clinical faculty, including the Department of Pathology, totals 265. There are 150 members of the resident staff at an intern and resident level and, in addition, there are fellows and trainees. Except for the medical students who number 79 per class, and the house officers and trainees, the entire faculty and staff have been, and are, specialists and/or sub-specialists in the broad sense. Most, but not all, are certified by the specialty boards.

Since our medical school at Chicago is relatively small, the hospital patient ma-



terial has been adequate for bedside teaching of the junior class, as well as the house staff. The senior year, which is almost entirely elective, provides out-patient experience and selected in-patient experience as the needs and interests of the student dictate.

### Assignment of Students

Since all patients are available for teaching purposes, assignment of medical students to patients in the OPD or in-patient services is done on the basis of appropriateness of the patient as a teaching case, and is entirely unrelated to his social or economic status. In fact, each patient is given a short descriptive brochure which explains that we operate a teaching hospital where, as patients, they will be involved in the medical school educational program. Patients are admitted to the hospital from the out-patient department; the emergency room; or directly; and go to private or semi-private rooms. (It is quite impossible for students or house staff to know without specific inquiry which patient is paying full charges and which is partly or wholly free. In most cases, even the attending physician is unaware of the financial status of the patient.)

Referral of patients in both the clinics and hospitals has always been easy and frequent. The patients profit from the generous employment of formal rather than corridor consultation. It is also true that consultation provides the physicians with a well-thought-out opinion which also serves as an economical way of keeping him abreast of some developments in areas of medicine in which he may not be an expert. In addition, the very free use of consultations assures that staff members will have the opportunity to see virtually all the material pertinent to any special research or teaching interest. Since all consultations are actually seen first by a resident and presented by him to the consultant, the education process extends to medical students and house staff.

Laboratory charges for patients have always been subsidized by the medical school. For many years all chemical analyses were carried out without charge. Although this practice no longer obtains, sufficient flexibility exists to provide analysis at free or reduced cost in the interest of the patient, the teaching group, or for clinical research.

### Organization of Faculty

The organization of the clinical faculty has been critically important to the success of the full-time group practice in the medical school. Each clinical department is divided *informally* into sections. This encourages the faculty members to develop relatively broad teaching and research interests and responsibilities as well as the relatively narrow area of subspecialty. Of greater importance is the fact that development of sections permits a sharing of clinical responsibility among members of a group, all of whom are of approximately equal clinical competence. Thus, it is possible in the non-surgical specialties, and especially in medicine and pediatrics, for members of the staff to work more or less continuously in the out-patient department, but take full responsibility for an in-patient service for only a limited portion of the year (three months). This division of departments into specialty sections has admittedly contributed to the discontinuity or fragmentation of teaching as well as of patient care. To reduce such curricular fragmentation, special courses are offered which tend to emphasize the whole rather than the parts. In addition, an intensive experience on a general medical hospital service is required of all students, as is out-patient experience designed to provide initial visit and follow-up experience. Continuity of care from the patient's point of view is provided by the fact that he is aware of the group, sees them work together, is confident that they generally think as one, and that they consult frequently with one another concerning problems. Physicians pay courtesy calls on their patients when not directly responsible for supervising their hospital care, and are aware throughout hospitalization, as a result of grand rounds within sections, of the conduct of cases. The average out-patient clinic responsibility of each member of the professional staff is two half-day clinics per week. Thus, barring committee assignments, the preparation of lectures, and in some cases administrative chores, the faculty members have an abundance of free time to study or carry on laboratory and clinical research.

There are no administrative rules and no contractual obligations requiring members of the clinical faculty to accept re-

sponsibility for patients; but, given reasonable attention to staffing, and the loyalty of most members of the faculty to the obligations for seeing that the institution functions, the service responsibilities have always been met. As one might expect, some members of the faculty lose their interest in clinical medicine and become exclusively interested in laboratory investigation. This phenomenon has generally been balanced by the changing interests of other members of the staff who have turned from research to become essentially full-time teachers and practitioners.

### **Philosophy**

Such is the group practice arrangement at The University of Chicago. It now seems appropriate to outline the philosophic advantages of this system.

From the point of view of the University, the hospitals and clinics are the property of the University and are completely under its control. This means that the hospital and clinics operate for the medical faculty—a faculty that wishes to see the patients well cared for as part and parcel of the needs of a medical school. No intermediary ruling body or agency needs to be considered for major or minor policy matters. The hospital superintendent, aside from financial consideration, clearly understands that he is running a university hospital and that it must be run in a manner that fulfills the needs of a diverse faculty with many different individual orientations. The faculty understands this, and is not hesitant in requesting—even demanding—what it wishes. It can be said that these requests for administrative considerations have seldom, if ever, run counter to the primary needs of patients. If the faculty is reasonable, imaginative, and moderately aggressive, it can have a clinical facility tailored to its requirements and desires for a medical school operation which is yet consistent with the best of medical care.

From the patient's viewpoint, many years of experience with a middle-class clientele attest to the fact that this group practice arrangement is providing something for which the public is willing to pay. Despite some inconveniences inherent in an institution oriented toward teaching and research, every increase in the facilities during their 40-year history has been promptly followed by an increase in the patient

population. About 20% of the patients are referrals from neighboring physicians. The remainder, who constitute the bulk of our patients, come expecting the clinics to become their personal physician. They apparently accept the fact that they have more than one physician, and that in the absence of the particular doctor who normally attempts to provide continuing care, there are others who are acquainted in a general way with the problem. They develop confidence that the young physicians in training accept responsibility for important decisions only after consultation with a supervising faculty member. Although home visits are rarely made, they are aware that the emergency room is their physician's front door, and that through it, all the facilities of the institution are available to them.

This responsible group of paying patients expects and receives courteous and respectful consideration from all members of the clinical staff. Working closely with the members of the faculty who are accepting responsibility for patient care in both the clinic and hospital service, the student sees a variety of different individual methods of practice and many examples of devotion to the care of the ill in situations in which no financial reward accrues to the physician for keeping the patient satisfied and well.

One might expect that the full-time group practice described, in which fees do not go directly to the individual, might reduce the incentive to contribute to patient care and tend to incline the physician more toward the research opportunity. This type of criticism or disadvantage is real but not confined to the system described. It is a national problem that has received attention in many quarters, and is more likely related to the greater availability of research funds than to the system under discussion.

### **Improved Medical Care**

For society as a whole, the University group practice provides the faculty and administration with the tools, mechanisms, and the materials for setting up experimental procedures in which improved medical care is delivered to the American public. It seems perfectly obvious that, within another decade or so, the medically indigent patient who does not now have



free choice of physician will have disappeared. To handle the increased patient load that will result from this social change and the anticipated population growth, a more efficient and effective means of providing this care must evolve. The parallel between the shift in the manufacturing industry from hand-crafted production to mass production techniques immediately comes to mind. The big question is whether mass-produced, more efficiently delivered medical care can measure up to the standard which the profession and the public expect. Can personal relations between patient and physician be preserved and even strengthened in a "medical factory"? The experience of our university group practice permits an affirmative response.

The manner in which students and resident staff have assisted while learning provides a basic model for schemes of incorporating paramedical personnel to a greater extent in group practices. Using this medical teaching program as a model, we are now in an excellent position to experiment with ideas for bringing more physician aid into medical practice. One can, for example, readily visualize the upgrading of the responsibilities of nurses and increasing the attractiveness of nursing to both men and women by having them assist more fully in activities that may range from history-taking to detailed instructions concerning management. Similarly, there are ways in which the skills of the nutritionist, social worker, physiologist, and perhaps even the nurse's aid could be worked into the medical care program in a manner that would increase the efficiency of the physician and improve the quality of care.

Aside from these experimental approaches for broader use of paramedical personnel, the group arrangement itself provides a substantial tool for assessing patient needs, studying society's attitude toward the physician, and evaluating the costs of medical care. The only effective means of increasing the value of the medi-

cal dollar is to reduce the need for hospitalization for diagnosis and study. The University group practice is in a leading position to develop approaches for the delivery of complete diagnostic investigation and much more treatment than is now provided on an out-patient basis through improved management procedures. The Government and Society are expecting leadership from the American medical schools in these matters.

Experience at The University of Chicago indicates clearly that those schools which have incorporated group practice arrangements as an integral part of their activities are in the best position to lead. At the same time, I wish to emphasize that the large group practice, as it exists at the Pritzker School of Medicine of The University of Chicago, is not suggested as a solution to *all* the problems of medical education nor to all the problems of American medicine so clearly delineated by the Coggeshall Report<sup>1</sup> and the Mills Report.<sup>2</sup> The system I have described, like other arrangements, has some shortcomings and problems as a model for medical school teaching. As pointed out at the outset, an historical accident created the full-time group practice plan at the medical school. It has been a successful experiment, but it may not be the ideal for every medical school, nor should its success preclude our own deviation from this model. In fact, its success should encourage the University to continue experimenting in an attempt first to improve medical student education and, second, to contribute to the solution of the many problems of medical care that beset our nation.

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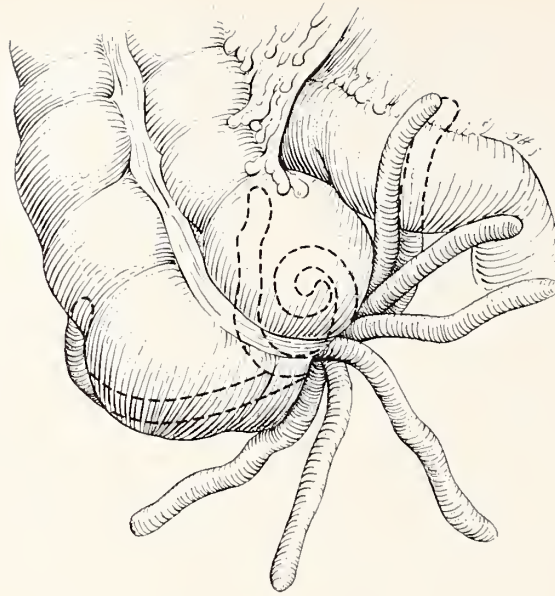
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### Specialization

Specialists as a class are exposed to a particular set of dangers including those of the narrowness and monotony of "piece worker," those of loss of adaptability, those of objectionable aggressiveness, those of stubborn opinionatedness, those of boastful self-sufficiency, those of selfish materialism, and those of vanity and arrogance.\*

\*Barker, L. F., in Richard Magraw: *FERMENT IN MEDICINE*, 1966.



Various Positions of the Appendix  
(after Kelly)

**Fig. 1** *Various Positions of the Appendix.*

## *Appendix Veriformis*

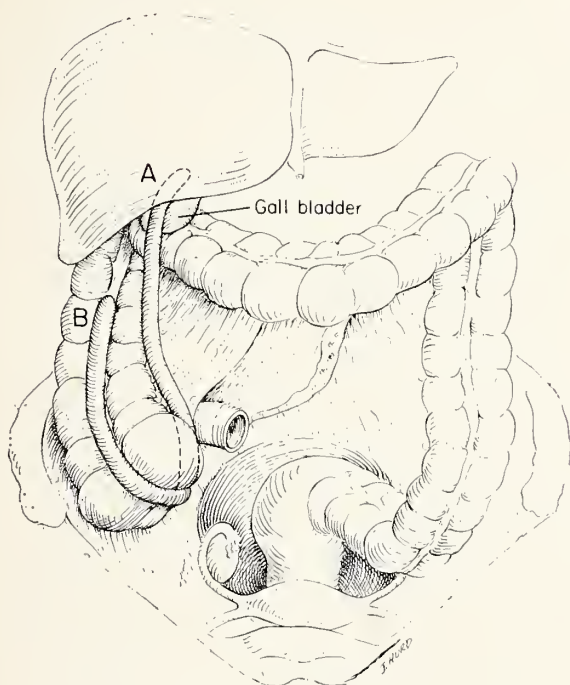
# An Unusual Anatomical Variation

BY VINCENT S. DiGIULIO, M.D., F.A.C.S./JOLIET

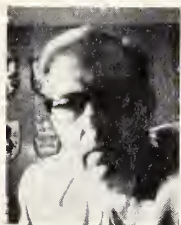
*Variations of the position of the appendix, as described in Kelly<sup>2</sup> do not show a variation which was discovered at celiotomy performed at Silver Cross Hospital of Joliet.*



- 2 *Case A is the case which is reported.*  
*Case B is a similar case seen a few weeks later.*



- A. Retro-caecal Intermesenteric Appendix  
 B. Intermesenteric Appendix



OB-GYN and Diplomate, American Board of OB-GYN.

Vincent S. DiGiulio, M.D., F.A.C.S., is a Joliet obstetrician and gynecologist. A graduate of the University of Illinois, College of Medicine, he is an assistant clinical professor of OB-GYN at the University of Illinois, College of Medicine. Dr. DiGiulio is a Fellow, American College of

## Case Report

Mrs. M.H., Silver Cross Hospital number 6802566, complained of pelvic pain and intra-menstrual spotting of one year's duration. Previous management with hot sitz baths and darvon had been unsuccessful. The patient was nulliparous. She was Negro, 27-years-old. Past history was not pertinent and physical examination revealed a third degree retroflexion of the uterus and fullness of the right adnexa. Routine hospital tests were normal.

A dilatation and curettage with cervical biopsy and celiotomy were preformed. The appendix was noted to be retrocoecal and coursing to the right of the caecum. It then coursed through the mesentery and peritoneum of the ascending colon and the tip end became sub-hepatic and was adherent to the gall bladder. The mid portion overrode the right ureter. The pathological specimen measured 9 cm., although at surgery the appendix was estimated at 14 cm. Otherwise the appendix was grossly and microscopically normal.

## Summary

An unusual variation of the appendix veriformis is presented. It is believed to be an original clinical situation.

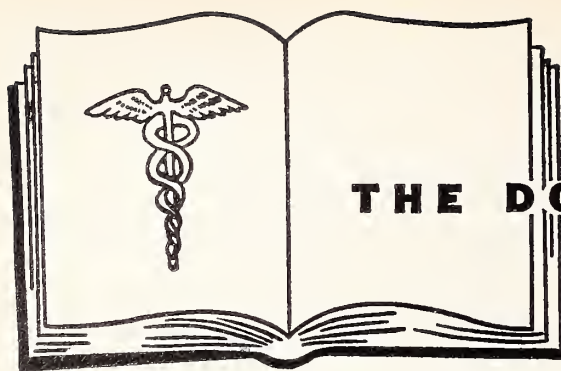
The etiological explanation of such a variation is unknown. The patient has had an episode of pyelitis one year earlier and one might hypothesize that the appendix was sub-acute at that time and through some unknown reason became adherent to the gall bladder. The possibility of a congenital explanation for the variation or excessive mobility could also be considered.

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## Acknowledgements

Dr. William F. Mengert, professor and head, Dept. of Obstetrics and Gynecology, University of Illinois, College of Medicine.  
 Miss Jane Hurd, Medical Illustrations, University of Illinois, College of Medicine.



## THE DOCTOR'S LIBRARY

**SYNOPSIS OF SURGERY.** By Richard D. Liechty and Robert T. Soper. The C.V. Mosby Company, St. Louis, 1968.

By emphasizing definition, etiology, pathology, and diagnosis, the faculty of the University of Iowa, College of Medicine, have written an excellent text for the student of surgery.

In the first chapter, a basis for understanding the nature of surgical disease is presented. The authors list six pathologic processes, and then show how the resulting phenomena of obstruction, perforation, erosion, and tumor lead to diseases which are treated by surgery.

Following are excellent chapters in which the current concepts of such basic surgical problems as wound healing, fluid and electrolyte balance, blood coagulation and transfusion, and shock are clearly explained.

While surgical diseases of various organs and organ systems are presented in a standard manner, the authors have interspaced several chapters which deal with the management of clinical problems caused by diseases of similar symptomatology. Thus, in an excellent chapter on the acute abdomen, the authors stress the recognition and differential diagnosis of the surgical abdomen, concluding with the admonition: "Spreading peritonitis or massive gastrointestinal bleeding are singularly immune to contemplation." Similarly, the subject of gastrointestinal hemorrhage is presented with a practical flow sheet for the management of the patient with massive upper gastrointestinal tract bleeding. The student will find such discussions particularly helpful in organizing the mass of information presented in a surgical text.

The authors have prepared several excellent tables in which clinical information is presented in a concise, easy to read manner. For example, the common congenital

anomalies are described in a table which includes the type, anatomic defect, clinical characteristics, treatment, age, and prognosis. Similar tables are used to describe such diverse subjects as pulmonary function, bone tumors, and occlusive arterial diseases.

The **SYNOPSIS OF SURGERY** is a well organized textbook which contains a vast amount of clinical information. More than just a compendium of surgical disease, this book will provide the student with a valuable tool for increasing his knowledge and understanding of surgery.

Stuart M. Poticha, M.D.

**CHRISTOPHER'S TEXTBOOK OF SURGERY.** Edited by Loyal Davis. W.B. Saunders Company, Philadelphia, 1968. 1,368 illustrations 720 figures.

The **CHRISTOPHER'S TEXTBOOK OF SURGERY** occupies a relatively unique position in the field, because of the frequent revisions which have now resulted in the appearance of the ninth edition of this textbook.

Since the previous edition which appeared approximately four years ago, the present volume has been carefully edited, and a number of new chapters have been added and previous chapters re-written by new authors.

The chapters on wound healing, infections, anesthesia, eyes, ears, nose and throat, the heart and great vessels, the liver and biliary system, the adrenal glands, the urinary system, and physical medicine and rehabilitation have been completely re-written by authors who did not participate in the previous edition.

New chapters include Oncology, Congenital Diseases, Trauma, The Neck, Artificial Organs, and Transplantation of Tissues and Organs.



The satisfactory organization of the book and the frequent revision has placed this textbook among the most informative of current textbooks.

The authors of the various chapters represent individuals who have made contributions in the field which they are presenting.

The volume has been edited carefully, so that there is a minimum of duplication—so often a problem in multiple author books.

In an effort to present information in all fields of surgery, there has, by necessity, been curtailment of some areas which may be considered important by many. For example, there is scant information concerning the pathogenesis and treatment of atelectasis. Again, the discussion of the

diagnosis of hyperparathyroidism is disappointingly brief and devoid of information concerning the more sophisticated laboratory methods. The virtues of the book, however, outweigh these inevitable shortcomings.

The illustrations are of high calibre. The references are comprehensive and carefully selected. The discussions of many areas, as exemplified by those of portal hypertension, diseases of the pancreas, and the genitourinary tract, are outstanding.

It must be concluded that the **CHRISTOPHER'S TEXTBOOK OF SURGERY** continues to be one of the outstanding books in its field and is recommended to all students of surgery.

John M. Beal, M.D.

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### ***Cardiovascular Surgery Booklet***

A publication entitled "Cardiovascular Surgery" (PHS Publication No. 1701), which describes the most recent advances in the surgical treatment of congenital and acquired heart disease, has been issued by the National Heart Institute of the National Institutes of Health.

As a result of National Heart Institute research support, along with other Federal and voluntary research funds, spectacular strides have been made during recent years in the field of cardiovascular surgery.

- Today corrective or palliative operations have been devised for most of the common inborn heart defects and for many of the rarer forms as well.
- With the development of better artificial heart valves and improved methods of sustaining the patient during prolonged open-heart operations, surgeons can repair or replace as many as three heart valves damaged by rheumatic fever during a single operation with good prospects of success.
- High blood pressure caused by atherosclerosis or blood clots interfering with the kidney's blood supply can often be cured by surgery to restore normal renal bloodflow.
- A variety of ingenious, totally implantable artificial pacemakers have

been developed to restore and maintain normal heartbeat in victims of heart block.

- Assisted-circulation techniques of "booster hearts" are being developed for maintaining normal blood pressure and adequate bloodflow to the body's organs and tissues while substantially reducing the workload of severely damaged or failing hearts. This temporary respite may enable damaged hearts to recover completely.
- And much research is presently being directed at the development of a completely implantable artificial heart to replace hopelessly damaged or diseased hearts.

These and other facts including available facilities and services, such as financial assistance, for the prospective surgical patient, are presented in the fully-illustrated "Cardiovascular Surgery."

Single copies may be obtained, free of charge, from the Heart Information Center, National Heart Institute, National Institutes of Health, Bethesda, Maryland 20014.

Quantity copies may be purchased at 45¢ per copy, \$33.50 per 100, from Superintendent of Documents, Government Printing Office, Washington, D.C. 20402.

# EDITORIALS



## A PREVIEW OF THINGS TO COME

Most hospital bills reflect hidden expenses. If this were not true, hospitals would be rich. In some instances hidden costs include research and teaching. The present trend is to reduce operational expenditures—a worthy consideration—except, many hospitals still lack accurate breakdown information and sophisticated accounting systems. With improvements in accounting and more realistic pricing practices, the pattern will change. Hospitals now realize that a closer correlation should exist between charges and costs.

According to Stanley R. Nelson, administrator, Northwestern Hospital (Minneapolis), proper utilization of resources is the single most important factor affecting costs. This implies an appropriate balance of beds and facilities in relationship to needs. The most encouraging signs leading to reduced costs are more hospital mergers and cooperative programs among these centers. Joint purchasing methods involving drugs and services such as printing, collections, and laundry also is more economical. And, in many instances, cuts down on the storage areas needed.

But the greatest pressures of rising costs are resulting from the unionization of pro-

fessional and nonprofessional employees. According to Nelson, the largest contract group involves the nonprofessionals: nurses aides and laundry, kitchen, and housekeeping employees. The following is their latest list of demands to the hospital.

- A 35-hour work week
- 20% increase in wage rates
- 10% shift bonus
- Time and a half pay for Saturdays
- Double Time pay for Sundays
- Triple Time pay for holidays
- Inequity increases where needed
- Longevity pay
- Paid funeral leave
- Paid voting time
- \$30 per year uniform allowance
- Unemployment benefits
- Increased pension contributions
- Major medical plan with complete coverage
- Cost of living escalator clause
- Union Shop
- Year 'round vacation scheduling
- Elimination of rotating shifts
- Periodic labor-management meetings
- One year agreement

T. R. Van Dellen, M.D.

## First Aid For A Burn—Cool It With Ice Cold Water

The immediate first-aid treatment for severe thermal burns with cold water compresses has been known by physicians for over 30 years. Documented proof of the

efficacy of cold water for burns has been reported by Ofeigsson in 1959 and King and Price in 1963.<sup>2-9</sup>

Recently two severely burned children



seen in our private practice were treated for extensive second and third degree burns. One of the children subsequently died of complications of her burns. In each case no cold water compresses were applied to the burns. Prompted by this unhappy experience, it was decided to screen several hundred mothers and children to determine how many would employ cold water as part of the immediate first aid treatment for thermal burns. Preliminary results showed that 59% of suburban mothers in our private practice knew the right answer. Only 22% of the mothers of children seen at the clinic at Children's Memorial Hospital, Chicago, answered correctly. A survey of suburban children between 8 and 18 years of age in our private practice showed that 39% knew the correct answer, while 12% of urban children of a similar age group seen at Children's Memorial Hospital knew the right answer.

The survey indicates a widespread lack of knowledge about the immediate first aid treatment of burns by mothers and children.

Questioning of some fathers and persons in the geriatric age groups indicates a similar lack of information.

This preliminary survey clearly shows the time lag which so often occurs in the transmission of vital medical information from the research paper to the people. The delivery of information on cold water for the first aid treatment of burns should have

a high priority. The U. S. Public Health Service has placed such a high priority on the expenditure of funds for accident prevention. Since burns carry an extremely high morbidity and a significant mortality, a national campaign is needed to alert all the people on the use of cold water in the first aid treatment of burns.

Harvey Kravitz, M.D.

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### Response to the Retarded Child

Mental retardation, as any other handicap, must be viewed as an attribute of an otherwise more or less intact organism. The retarded or emotionally disturbed child has never ceased to be a child, a fact never to be forgotten. Throughout the various phases of their ongoing development, the handicapped and the ordinary child have much in common and are more similar than different in basic needs and requirements. They both are subject to the stresses and formative influences of interpersonal relationships in their environment, at home, at school, and at play and work, and respond to them with a similar repertoire of emotional responses.

Allowance must be made for a number of distinguishing features: the retarded child progresses at a slower pace and rate than the ordinary child to the successive milestone of development; with increasing age he lags more and more behind his contemporaries in adaptive behavior and mastery of reality. He therefore lacks adaptability and flexibility under changing circumstances, and prefers repetitive or monotonous routine activities to which he is limited. He has not advanced to develop his emotional equipment, i.e., adequate and mature adjustive patterns, strategies and defenses that would enable him to maintain his emotional equilibrium under ordinary stresses. All this accounts for his prolonged dependency. (Leopold Hofstatter and Lilli Hofstatter: "Emotional Problems of the Child with Mental Retardation and His Family," *Southern Medical Journal* 62:5 [May] 1969.)

# Prescription For The Minister

BY ORVILLE S. WALTERS, M.D., PH.D., F.A.C.P./URBANA

"I don't want any preacher around upsetting my patients." This remark was made twenty years ago by a medical colleague following a joint meeting of physicians and ministers. The coolness toward the clergy reflected in this blunt comment is far less common today. In the two decades that have intervened, medicine and religion have been brought much closer together in their care of the patient. The hospital chaplain has become well recognized and respect for his ministry has widened.

The era of partitioning the patient is coming to a close. For many generations, his soul was assigned to the clergyman and his body to the physician. The doctor had the responsibility of keeping the body in shape to carry the soul as long as possible, but disclaimed any competence or responsibility for spiritual counsel.

The minister, having oversight of the spirit of man, tended to look upon his responsibility as the greater. The physician was inclined to consider his assignment not only more complicated, but considerably more urgent. The patient, for his part, tended to give priority to the division that was causing him the most discomfort, and to place the highest value upon the ministrations that cost him the most.

## Personality Division

Theology has long had its own apportionment of personality according to the Greek terms used in the New Testament. *Psyche*, *pneuma* and *soma* became mind, spirit and body. However, closer study of Greek and Hebrew word usages have made it clear that in the Pauline epistles such "part" words usually signified the whole person.

Freud first divided personality into conscious and unconscious, but later replaced this stratified model of man with his structural theory, which separated personality into id, ego and superego. The psychoanalytic fractionation of man was tempered considerably by the influence of Adolph Meyer, who advocated the longitudinal study of the whole man in relationship to his environment. Other European depth psychologies have also laid stress upon studying the person in his world.

In both theology and in medicine, the holistic viewpoint is now firmly established. The remarkable growth of psychosomatic medicine, which has demonstrated the importance of emotional factors in physical illness, can be given much credit for today's emphasis upon the whole person in both medicine and in pastoral care.

As the doctor's view has been broadened to see his patient as a person rather than as a clinical entity or a diagnostic complex, there has come increasing recognition of anxiety as a symptom or a concomitant of somatic illness.

The physician recognizes that instead of merely blunting the anxiety by tranqui-

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lizers, which is treatment of the symptom, he should trace the anxiety to its source and treat the cause. In this endeavor, the minister may often be an effective collaborator because of his prior acquaintance with the patient's emotional stress or because of ready access to a parishioner's personal problems. The religious resources mediated by the minister may also commend him as a therapeutic colleague on some occasions. The concept of the therapeutic team, which has arisen and has been employed with great effectiveness in the mental hospital, is being adapted for more general use by looking upon the hospital chaplain or the patient's minister, along with nurses and adjunctive therapists, as members of the healing team.

### **The Minister as a Collaborator**

The acceptance of the clergyman as a co-worker with the physician in the ministry to the sick necessarily involves extensive adjustments by both. The physician is accustomed to giving orders and having them carried out by others, such as nurses, pharmacists, adjunctive therapists, and technicians. He makes pronouncements for other people that may keep them home from work, excuse them from school or even exempt them from the draft.

The minister, too, is accustomed to being the center of attention. He speaks while others listen. He leads and others follow. He presides at meetings and calls others to order. He is a spokesman, an oracle of morality, a judge, a counselor, perhaps a psychotherapist. In all these roles, he holds the spotlight. If he is not egocentric when he enters his profession, his ministerial duties tend to make him that way.

The physician and the minister are both proud professional men, accustomed to receiving the respect and approbation of others. Perhaps the greatest obstacle to be overcome in a joint working relationship is that each must defer in some measure to the other.

**The minister's teamwork.** In accepting a working relationship as a member of the healing team, the minister must be able to subordinate his own egocentric needs. The physician is quarterback and captain of the team. He calls the signals that even the minister must follow if there is to be a smooth working relationship. Since the advantage of a team is that individual ef-

forts are mobilized and focused for the good of the patient, failure of one team member to coordinate his efforts with the rest may neutralize the entire effort. Criticism of the treatment program selected by the physician, or any lack of confidence, whether expressed verbally or conveyed in some other way, may disrupt the healing effort or even the working arrangement itself. Communication among team members must be maintained at all times. If the minister has misgivings about the progress of the patient or the course of the treatment, it is important for him to discuss the matter directly with the physician, never with the patient. The minister, as well as the physician, must ever keep before him the medical maxim, *non nocere*, to do no harm.

**The minister's personality.** The sick patient tries to read in the faces of those who care for him what is unspoken. He is quick to intuit their feelings and attitudes. It is important that no anxiety overflow from their personalities into his. Rather, he should be able to draw strength and reassurance from them. The minister must have mastery of his own anxieties and an additional margin of strength great enough to inspire others. He must be sufficiently sensitive to the suffering and the needs of others to be responsive, but not be moved enough to tip scales that are already heavily loaded on the side of self-pity and depression.

He must have inner strength and self-discipline that will not crumple in the presence of crisis, yet he must not develop a hard veneer of professionalism. He must have enough security and self-esteem so that he does not need to sustain it by medical name-dropping or by hinting at the confidences that are a part of his professional relationship. He must be perceptive of the patient's unspoken needs and communications, as well as those of others who come and go in the sick room, whether hospital employees, relatives, or professional people.

**The minister's faith.** The minister must exemplify the kind of love that is central in the Christian faith, love that is bestowed even when it is unearned and undeserved—the *agape* of I Corinthians 13. As God loved man while he was "still in the wrong," so those who would be godly will grow in their ability to love those who are unlov-

able and unlovely. After examining New Testament love, Sigmund Freud was willing to offer love on a *quid pro quo* basis, but pronounced *agape* "unpsychological."

Pastoral counseling has had much to say about acceptance of the patient as an important aspect of the minister's priestly role, but not so much about the minister as prophet. Even though the minister himself may not stand in judgment upon his parishioner's wrong-doing, his office does. In the eyes of his people, the minister is the symbol of law as well as of grace, whether he relishes the part or not.

In the sickroom, however, the priestly function comes first. Most people who are ill, even though not seriously, are already burdened with their own guilt. The pastor's ministration will more often need to diminish than to increase that load. The Good News of forgiveness may be needed to restore confidence and may contribute significantly to the healing process. The missteps and the errors of one's life are passed in review during the lonely hours of illness, and are magnified by the distortion that malaise and depression bring. The clergyman comes not only as a person who cares, but as the representative of a forgiving God, who loves even when love is undeserved, and who forgives without

limit.

The faith by which the minister himself lives is as important as that which he preaches. His faith cannot be expected to do any more for others than it does for him. The depth and effectiveness of his own faith is sure to be sensed by those to whom he ministers. He cannot expect to be free of anxiety. The great apostle wrote about "the daily pressure on me of my anxiety for all the churches" (2 Cor. 11:28). Neither is the minister ever likely to be completely free from some sense of guilt. Even the most saintly have been increasingly sensitive to their own shortcomings as they have become aware of spiritual possibilities still unattained.

Broadening the physician's concern to include matters of the spirit has made his task more complicated, but it has moved the minister from the periphery into the inner circle where he can contribute more directly than ever before to the patient's welfare. In many places, the concept of the healing team is still on trial and the clergyman may be only a probationary member. If he can demonstrate his value and establish his trustworthiness, the minister has impressive potential as a medical collaborator. ◀

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## Film Reviews

"Silent World, Muffled World," is the title of a new film narrated by actor Gregory Peck in which the physiology of the ear, the mechanics of the hearing process, and the hearing impairment caused by certain disorders of the outer, middle and inner ear are outlined.

Recipient of the blue ribbon at the American Film Festival, the film is recommended for showing to civic, educational, voluntary and professional health groups, including medical and para-medical professions. Contact: National Medical Audiovisual Center (Annex), Chamblee, Georgia 30005, Attn: Film Distribution.

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In conjunction with the AMA and component medical societies' efforts to attract

more black students to the study of medicine, the film entitled, "You Can Be a Doctor," is now available. The 15-minute color film may be secured by writing: International Afro-American Museum, Inc., 1549 West Grand Blvd., Detroit, Mich. 48208.

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Two series of 16mm. teaching films on human anatomy and current concepts and practices for cancer management have been produced by the American College of Radiology. The series on normal anatomy uses cinefluorographic techniques to show how organs function in living people.

The films on both cancer management and normal anatomy may be borrowed from the AMA, Film Library, 535 N. Dearborn St., Chicago, 60610.



# *Effect of*

# *Maternal Virus Infections*

# *On The Fetus*

BY ALWIN C. RAMBAR, M.D./HIGHLAND PARK

## **Part I**

In recent years many factors have been implicated in the cause of fetal abnormalities. This revue is primarily concerned with the current knowledge of the response of the conceptus to viral infection originating in the mother. The pregnant woman may, of course, be exposed to any viral disease, with the incidence of exposure in direct proportion to the number of children in her family. Reviews of this subject indicate that most viral diseases can occur during pregnancy, and that in some instances congenital abnormalities or other deleterious effects on the fetus may result from these infections. Until practical and easily performed tests to positively identify specific viruses become available, we must rely on prospective studies to establish an etiological relationship.

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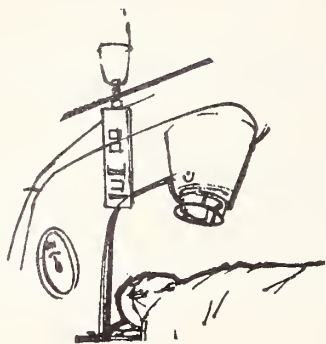
This is Part I of a two part article by Dr. Rambar. The second installment will appear in the November issue of the *Illinois Medical Journal*.

Besides the anomalous development of the fetus caused by the rubella virus and the cytomegaly viruses, other known effects are abortion, stillbirth, and increased perinatal and maternal mortality. In the great influenza pandemic of 1918, Harris<sup>1</sup> studied the records of 1,350 pregnancies of severely infected women, and found that pregnancy was interrupted in 26% of the uncomplicated cases, and 52% of those with complications, who survived. Over 50% of the severely infected mothers died. At least in this disease, the more severe the infection, the greater the likelihood of fetal wastage.

### **Infection of the Fetus**

The means by which the fetus is infected is speculative. The association of viral lesions in the offspring with preceding or concomitant maternal disease is well documented when it occurs by first infecting the mother. The virus could conceivably ascend from the outside via the vagina, through the os cervix into the uterus. However it is more likely that the virus produces a viremia in the mother, crosses the placenta and directly involves the baby. It is known that smallpox, mumps, varicella, rubella, infectious hepatitis, cytomegalic inclusion disease, vaccinia, poliomyelitis, group B coxsackie and other enteroviruses may all cause abortion or stillbirth, especially when the disease is severe and occurs early in pregnancy. Fetal effects may occur in virus infections where vire-

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mia is not believed to occur, as in influenza. Parrot<sup>2</sup> believes that there may be an active physiologic process by which the virus or metabolic products are transmitted to the fetal circulation.

Villie<sup>3</sup> tabulated reports of tissue sections from fetal organs obtained at the time of birth which showed that virus can be transmitted through the placenta. Potter<sup>4</sup> demonstrated cytomegalic inclusion bodies in the kidneys, in the cells of the bile ducts, and in the brain of a fetus. Kibrick and Benirshke,<sup>5</sup> in an autopsy of a seven-day-old infant with myocarditis, described the first case of a coxsackie virus isolated in the tissue of a human being. This was an apparent transplacental transmission of a virus from a mother with a minor respiratory infection, with resulting fatal disease in the newborn. These authors<sup>6</sup> subsequently reported two other cases and reviewed 25 similar ones in the literature.

Herpes simplex virus was first isolated in the liver of a newborn infant by Zuelzer and Stulberg<sup>7</sup> in 1952. There was a history of recurrent herpetic lesions on the mother's labia, and the findings of early herpes lesions in the baby's conjunctiva and eyelids strongly suggest that the infant acquired the disease by contact during passage through the birth canal. The additional finding of herpetic glossitis and esophagitis is in keeping with the assumption that infected maternal secretions also entered the oral cavity at birth.

## Immunologic Responses

There is evidence that the infant's mechanisms for producing a specific immunologic response are developed by the time of birth.<sup>2</sup> The response to microviral invasion is deficient in immature animals and this is in part responsible for the extreme susceptibility of the very young. Smith and Eitzman<sup>8</sup> have shown that immunoglobulin response is less in the newborn than in the adult. Holland<sup>9</sup> demonstrated that a greater number of tissues of the immature animal are specific receptor sites for viruses than those of the mature animal. Parrot<sup>2</sup> has postulated that if the maternal virus reaches the fetus it would be possible at a cellular level to damage or completely destroy the infected cell. The effect, then, in the total organism, would depend on the state of development of the cell. Eichenwald and Shinefield<sup>10</sup> state that the lethal effect of a given amount of viral multiplication is greater for immature than mature cells. According to Medearis,<sup>11</sup> the net effect of all of the inadequacies of host defense is that the immature host is extremely susceptible to the wide dissemination and the resulting destructive effects of viral infections. In view of this susceptibility of immature animals to viral infections, death of the embryo could easily result from a virulent virus. Since abortion and stillbirth frequently follow gestational rubella, there is evidence that the maternal virus-human embryo interaction is essentially destructive. Cooper<sup>12</sup> has shown experimentally that rubella virus causes human chromosomes to break up. Also, cultures of human cells infected with the rubella virus grow at a slower rate than non-infected cell cultures. Thus, if maternal virus reaches the developing cells, the damage which may result depends on the state of the cells' development. Potter<sup>13</sup> quotes Ebert as suggesting that "perhaps the fortunate limitation of animal viruses as teratogens in man is related to the lack of specific attachment sites for viruses in the embryo. In the case of rubella then, one might postulate that the virus requires no specific attachment site, or that the site develops precociously in the cell surfaces of the human embryo. It could be that the action of rubella is an indirect one, involving the production of a maternal immune state, the viruses acting as an adjuvant in



the production of antibodies which may be effective against the embryo."

Another factor is that the maternal disease may be severe enough to cause hypoxia, as in influenza, or there may possibly be a deleterious effect on the maternal nutrition, the acid-base balance, or the state of hydration, any one of which might have an effect on the conceptus.<sup>2</sup> Perhaps there is an active physiologic process in which virus or other metabolic products are transmitted to the fetal circulation, just as other proteins are.

### Animal Studies

Ample evidence of the effects of virus on animal embryos has accumulated. Duran-Reynals<sup>14</sup> administered ROV's sarcoma virus to chick embryos and produced lesions containing abundant virus. With advancing age, however, the chicks became more resistant to the virus. Ebert and Wilt<sup>15</sup> inoculated vaccinia virus in fowl embryos at 12 to 14 days and found that most of the embryos died 72 to 96 hours later, and the virus could be recovered from the embryos' circulation. Hamberger and Habel<sup>16</sup> inoculated 48-hour chick embryos with influenza A and mumps virus. No specific abnormalities resulted from the mumps virus, but influenza A evoked microcephaly, twist of the axis, and retardation of amnion growth. They found that the influenza virus is lethal for early embryos within 3 days after injection, while the mumps virus is lethal within 5 days. They believed that this experiment placed influenza A virus as a teratogenic agent. Noren<sup>17</sup> reported that a condition similar to endocardial fibroelastosis was found in chicks infected with mumps virus during the very early phases of differentiation. A persistent gestational infection, marked by high virus titers in the heart, was followed by myocarditis during late fetal life. EFE followed eventually. He proposed that mumps virus as well as perhaps other viruses may cause inflammation of the fetal heart muscle which may subsequently heal completely, or in some cases result in endocardial fibroelastosis. Ferm and Kilham<sup>18</sup> inoculated hamsters with rat virus and showed that if embryos of these animals were to survive an infection in early pregnancy, the effects would have to be minimal.

To relate this to man, Medearis<sup>11</sup> states that in the only proven instance of viral altered ontogenesis, rubella infection, the disease in the adult may be very mild, but the results can range from abortion or stillbirth to varied anomalies. Recent interest<sup>19</sup> has been directed toward rat viruses H-I and R-V (serologically related to the H-3 virus). Reports of the isolation of these viruses from human fetuses suggest that these may be responsible for human fetal morbidity and mortality. Experimental studies in hamsters have shown that these viruses are capable of producing fetal death or mongoloid-like changes when injected during the pregnancy. Serum studies were made on 133 women whose pregnancies terminated in spontaneous abortions, stillbirths, congenital defects, or mongolism, and compared with 266 matched normal contacts. Antibody to H-I or R-V was found in only two women, and the only infection as manifested by a significant rise in antibody titer occurred in a woman who delivered a mongoloid child. The authors felt that their studies do not preclude the biological significance of these viruses, but found no evidence that they adversely affect the population. Traub<sup>20</sup> has shown in mice, that congenital lymphocytic choriomeningitis virus infection produces multiplication of the virus throughout the life of the host. Blattner and Heys<sup>21</sup> demonstrated that the character of the abnormalities produced by the pathologic effect of viruses, depended on quantity and virulence of the virus, on the genetic type and conditioning of the host, and on the stage of development at which time the virus infects. Medearis<sup>11</sup> concludes that in view of the extreme susceptibility of immature animals to virus infections, one might assume that the death of the embryo would be the most likely outcome if it became infected, and that only a virulent viral infections would be compatible with the survival of the embryo, and the subsequent birth of an anomalous individual.

### Little Confirming Evidence

Despite the wealth of research material published on animal virus infections, aside from rubella there is relatively little proof that viruses produce great numbers of anomalies in the human. As more evidence accumulates however, there is increasing

reason for suspicion. Fraser<sup>22</sup> postulated that if congenital malformations result from infectious agents, we should have epidemics of malformations, as occurs with rubella. Baron et al,<sup>23</sup> and Dumont<sup>24</sup> were also unable to indict other specific viruses as teratogenic agents. Ebert<sup>25</sup> felt that data are so conflicting and sketchy, that their significance cannot be regarded as established. At a symposium on intrauterine defects, Katz<sup>26</sup> declared that the viral hypothesis has yet to be excluded or established as a possible etiologic factor in the majority of malformations. The viral hypothesis exercises its attraction because of the ubiquity of viruses and their ease of replication in laboratory animals, but such arguments may prove traps for the unwary, he asserted.

In the human, attempts have been made to prove the relationship of maternal virus infections to their effects on the fetus. Corston and Mirchandini<sup>27</sup> investigated 47 cases of congenital abnormalities and found suggestive symptoms of virus infection in the first trimester in 15 mothers. They did amniocentesis studies, and in two women a virus was recovered from the fluid. In one, an Echo #6 virus was found, resulting in the pregnancy proceeding to term with a normal fetus. In the other, mumps virus was recovered in the second month of pregnancy, and the patient aborted at 3 months. Grönvall and Selander<sup>28</sup> reviewed 354 pregnancies and found that if abnormal offspring resulted, a history of maternal virus infection was 10 times as great as when normal infants were born. Roszkowski and Kietlinska<sup>29</sup> analyzed the data of 149 viable and stillborn infants with developmental defects during a three year period, and found that in 50 of these, various maternal infections could be detected. Nora et al,<sup>30</sup> in a study of 240 mothers carefully observed during their pregnancies as to possible exposure to teratogenic agents, found that 28 (12%) had some form of acute illness in the first trimester. Two infants with major anomalies were born to this group. It does not appear that any of these observers have proven a definite teratogenic effect of virus.

### Rubella

Dr. Norman Gregg's<sup>31</sup> discovery of the relationship of rubella and congenital cataracts in 1941 has provided the basis of extensive research in the relationship of

maternal virus infection and the fetus. The large American epidemic of 1963 and 1964, has produced the opportunity for extensive study of the fetal aspects of this disease. Swan<sup>32</sup> detailed the increased risk of abortion, stillbirth, congenital malformations of the eye and heart, deafness, mental retardation, microcephaly, small size at birth, failure to thrive, and an increased mortality rate during infancy. There are marked variations in the reports of the number and percentage of infants born with the congenital rubella syndrome. Many subtle changes may occur which are not easily recognized and may appear later. Certainly deafness is not often ascertained before three months of age. The excellent British Ministry of Health<sup>33</sup> study which followed the infants born of rubella infected mothers for three to five years, showed impairment of hearing in 19%. Of 57 children following maternal rubella in the first 18 weeks of pregnancy, 15 had major congenital defects, while 8 had minor ones. Preliminary studies of 6,000 pregnancies in the 1964 epidemic<sup>34</sup> showed that 10% of clinically infected women delivered babies with recognized rubella syndrome. Many babies are born with the syndrome after inapparent illness in the mother. Hardy et. al,<sup>35</sup> have reported in detail a study of the effects of rubella occurring between the 14th and 31st week of pregnancy, in 24 women. Two mothers suffered fetal loss, and of the 22 children remaining, 15 are suspected of being abnormal. By one to three years of age, four infants were undersized, eight had small heads and six had a significant decrease in hearing. Seven of the 22 have some degree of motor or mental underdevelopment, and two have congenital heart disease. They conclude that fetal infection in the second trimester is more subtle than when it occurs early, and that the changes are more likely those that result from chronic viral infection, rather than from the teratogenicity leading to faulty organogenesis, as occurs in the first trimester.

The congenital rubella syndrome has been expanded, after the unusual opportunity to study large numbers of these babies, to include thrombocytopenic purpura, hepatosplenomegaly, anemia, encephalopathy, pneumonitis, jaundice, bone lesions, kidney anomalies, jejunal atresia,



biliary atresia, hypospadias, cryptorchidism, possible nephritis, glaucoma, myocarditis, abnormal dermoglyphics,<sup>45a</sup> and some previously unreported heart anomalies.<sup>36-46</sup> An increased incidence of indirect inguinal hernias<sup>35</sup> has been noted. It is interesting to note that although thrombocytopenic purpura seemed a new finding in 1964, it had been described in a newborn with congenital rubella with cataracts, in 1946.<sup>47</sup>

Since the isolation of the rubella virus, it has been determined that the virus may persist in the baby's tissues for many months, especially in the pharynx, urine, eyes, and cerebrospinal fluid. It does, however, eventually disappear. The isolation of the virus has provided the basis for the knowledge that many patients exposed to rubella may have the infection with no clinical disease. Although the incubation period of rubella is 14 to 21 days, the virus begins to shed from the nasopharynx as early as 7 days before the appearance of the rash. Without viral studies, it is difficult to be certain of the diagnosis from clinical signs alone. A comparison of four methods available for the detection of rubella antibodies, namely the hemagglutination inhibition, neutralization, fluorescence, and complement fixation tests has been made by Sever et al.<sup>48</sup> Their conclusion is that the hemagglutination inhibition (HI) test is the one of preference, since it is rapid and convenient for obtaining reliable information of the antibody status and susceptibility of the individual being studied. If a woman in the first trimester of pregnancy is suspected of having been exposed to rubella, the HI test should be performed. If the titer is less than 1 to 10, it means that there is no rubella infection, but should be repeated in two weeks. If the first test shows a titer of more than 1:10, it may mean either that she now has, or has had rubella. If a repeat test two weeks later shows a rise fourfold or greater over the original test, it is evidence that the patient has developed rubella.

Bellanti<sup>48a</sup> notes that the only immunoglobulin which is normally transmitted transplacentally to the newborn is the 7S $\lambda$ G-immunoglobulin. In his series of 6 rubella infants studied, each showed prominent  $\lambda$ M-immunoglobulins, and he believes that the levels of these indicate synthesis by the infant, as a result of stimulation

by the infection.

If therapeutic abortion is considered, the diagnosis should be proven by one of the acceptable tests, and then the patient and doctor must consider the mathematical probabilities, and the sociologic, psychologic, and religious factors involved. Proof of the presence of virus might be obtained by amniocentesis. The legal aspects of abortion vary so in different states that this unfortunately must influence the doctor's position materially.

### Varicella-Zoster

Chickenpox and herpes zoster may cause severe disease in the adult, and there are a number of authenticated cases of intrauterine transmission of chickenpox. The most recent report<sup>49</sup> of 10 pregnant women with varicella, and one with HZ, showed that 8 delivered full term normal infants. Five of these mothers had the disease within a week prior to delivery, and 3 of the newborns developed chickenpox. Of the 5 infants studied, one had detectable antibodies and did not become infected, while the 3 who did had no detectable antibodies. The remaining infant died from chickenpox. Manson, Logan, and Loy<sup>33</sup> tabulated 288 pregnancies complicated by this disease, and while there were 5 stillbirths and 8 deaths within two years, only three could be related to chickenpox. There were 4 abnormalities in these 13 infants, but this was no greater number than in the controls. Laforet and Lynch<sup>50</sup> reported a case of multiple congenital defects in a newborn following maternal varicella. Adkisson<sup>51</sup> described a newborn premature infant with typical herpes zoster at 30 hours of age. While this case (and all others developing prior to 8 hours of age) must be assumed to have been transmitted placentally, the 17-year-old mother could not recall having had chickenpox and had no knowledge of any exposure. Duehr<sup>52</sup> has reported that HZ is a cause of congenital cataracts when the disease occurred in the first trimester. In his article, other defects are recorded. Brunell's<sup>53</sup> conclusion that malformations in infants whose mothers had varicella during pregnancy, are so infrequent as to make an etiologic relationship between maternal infection and fetal abnormalities unlikely, is shared by most observers.

## Herpes Simplex

There are numerous reports of herpes simplex infection in the newborn, and while the clinical manifestations may be mild, most of the reports describe a disseminated form of the disease involving the heart, lungs, visceral organs, and the CNS. Nahmias et al,<sup>54</sup> have reviewed the current knowledge of the risk to the fetus and infant, of herpetic infection of the mother during pregnancy, and conclude from their own extensive studies and others, that the source of infection is either herpes labialis or genital herpes. They state that no definite association between herpetic infections during pregnancy and congenital abnormality has been recorded, nor is there any evidence of virus persistence in the infected fetus. Wheeler<sup>55</sup> reported a case of fatal pulmonary herpes simplex, probably acquired during passage through the birth canal, in a mother with primary herpetic vulvovaginitis. A globulin containing significant amounts of herpes neutralizing antibody given to the mother before delivery and to the baby after birth, failed to alter the fatal result. Hovig et al<sup>56</sup> have described three infants with non-vesicular cutaneous lesions which may have represented the first manifestations of HV infection, all of whom developed recurrent lesions. In one, herpes virus was isolated at 7 days of age, another at 4 days, and the third at about 9 months. As none of these mothers had genital lesions, it was protracted that the infection occurred in utero, possibly transplacentally. Others<sup>57</sup> have reported placental lesions histologically compatible with HV infection.

It is recommended that where exposure of an infant born in a third trimester infected mother has occurred, serologic studies should be done on the mother to determine the presence of antibodies. If the mother has circulating antibodies, the risk to the baby is probably minimal, although localized vesicles may appear. In the case of genital herpes, caesarian section should be considered and large doses of A globulin (20-40mmL. to the mother, and 10-20 ml. to the infant) may be administered at birth.<sup>54</sup> Isolation from the mother is imperative.

## Smallpox

In variola, pregnancy may be terminated

prematurely, especially at the height of the toxemia. Fetal mortality depends on the severity of the disease and the gestational age of the embryo. In the United States very few have had first hand experience with smallpox, but voluminous reports from the past, and from other parts of the world, attest to the fact that the mortality for the conceptus is increased in maternal smallpox. Abortion and stillbirth are also increased, with pregnancy being terminated before term in 40-60% of the cases. The disease may be acquired in utero and the baby born with typical smallpox scars.<sup>58</sup> Kibrick<sup>59</sup> referred to 47 cases of smallpox in pregnant women in which the child, often premature, had either a pustular eruption or healed smallpox scars present at birth. The disease may also be acquired in the passage through the birth canal. Schick<sup>60</sup> stated that the virus of smallpox crosses the placenta readily and that the fetus may acquire the disease in utero, even if the mother is apparently immune as a result of previous infection or vaccination. Blattner and Heys<sup>21</sup> note that women in smallpox areas are aware of this danger and do not nurse their infants.

## Vaccination (Vaccinia Virus Infection)

There are statistics available of massive population smallpox vaccination programs with no increase of abortion, stillbirth, or infant deaths. Bellows et al,<sup>61</sup> found no ill effects to the fetus from vaccinating about 5,000,000 persons in New York City in 1947, many of whom were pregnant women. In a series of 500,000<sup>62</sup> vaccinated in Glasgow, a previously unvaccinated woman 3 months pregnant, had a severe reaction to a vaccination and delivered a 6 months premature infant who died 15 hours later with typical vaccinia skin lesions. MacArthur<sup>63</sup> presented the results of a prospective study of 203 women vaccinated at different periods of gestation and noted that when vaccination was done in the first trimester, there appeared to be a significant increase of fetal loss, restricted to those vaccinated between the 4th and 12th weeks. Other authors<sup>64-65</sup> have reported mothers given primary vaccination in the 19th and 22nd week of pregnancy, each of whom aborted, and disseminated dermal and visceral lesions were found in the offspring. On the other hand, Abramovitz<sup>66</sup> found no increase



among recently vaccinated women, in either stillbirths, neonatal deaths, or congenital malformations.

Hardy<sup>67</sup> states that it would appear that smallpox vaccination during early pregnancy probably entails no substantially increased risk for either the mother or the fetus, but because in some instances it may lead to abortion or fatal transplacental infection of the fetus, it is best not done during pregnancy, unless strongly indicated by exposure to smallpox. However, Fish<sup>68</sup> advised that revaccination during pregnancy does not carry any significant risk to either

the mother or the child. The Council on Environmental and Public Health<sup>68a</sup> in 1968, listed among other contraindications to vaccination, pregnancy. Kempe<sup>69</sup> who has written convincingly on changing attitudes towards vaccination does not list pregnancy as a contraindication. It hardly seems necessary to vaccinate or revaccinate a pregnant woman unless she is travelling to a high risk area. Since an attenuated vaccine may become available, if a primary vaccination is imperative this procedure can be employed, presumably with safety.

*(To Be Continued in November IMJ)*

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### **"WHAT KIND OF A MEMBER ARE YOU?"**

. . . Are you a "checkbook" member who promptly pays his dues and then retreats from further involvement, hoping, always, that there will be others to do the work?

. . . Are you the "prestige" member who is willing to allow his name to be used for promotional purposes, but who will flee any personal responsibility or active leadership?

. . . Are you the "coattail" member, who is proud to display the membership certificate on the wall, but too timid to get involved?

. . . Are you a "chronic joiner" who belongs to everything and is too confused to fix logical priorities for himself?

. . . **Or are you a fully effective member?**

The less effective types of members want to help a good cause, without being bothered about issues.

They will fly across the country at their own expense to attend some pleasant ritual in the White House Rose Garden, but won't turn up at their local society's Annual Dinner.

They will go to their state organization's Annual Dinner if there's a chance of meeting the governor.

By ducking meetings where problems are discussed, these members are limiting their organization's influence in their solution. Outsiders, including government officials, will never be more enthusiastic about a program for attacking a problem than the members themselves are.

If you are concerned about some of the current troubles, the best way to strike back is to be a more "practical" member of your voluntary organization.

Arch N. Booth  
Executive Vice-President  
Chamber of Commerce of the U.S.

*The Good, the True, the Beautiful! Alas, the Good is so often untrue, the True so often unbeautiful, the Beautiful so often not good.—Isaac Goldberg*

# Extended Care Facilities and the Geriatric Patient

BY MARSHALL A. FALK, M.D./CHICAGO

The concept of post-hospital treatment of geriatric patients has evolved slowly over the years, and was supposedly standardized on July 1, 1967. At that time the federal government, through Medicare, began paying for 100 days post-hospital care for each spell of illness in approved nursing homes. The accreditation of these facilities was given by state and local agencies if it was determined after on-site inspections that skilled nursing care was being given, adequate records were kept, utilization review committees had been provided for and other specifications had been met, not the least of which was that the patient be under some kind of non-custodial active treatment. Prior to this, patient care varied from community to community and the quality of care was poor. Nursing homes in the form of extended care facilities must assume a new status in medical care.<sup>1</sup>

## Problems

The use and abuse of such extended care facilities has been compounded by many factors. First, the ever growing number of patients who are eligible for such treatment is rapidly expanding. It is estimated that by 1970 there will be 20 million people over age 65, and there will be 28 million in this age group by the end of this century.<sup>2</sup> Most of these people are already eligible for Medicare benefits, and the geriatric patient is undergoing a change in status from applicant to claimant of health care.

Secondly, the growing shortage of acute hospital beds, along with rising hospital costs, has forced the hospital administrator, hospital utilization review committees and the physician to use their ingenuity to relieve this daily crisis. A national health survey<sup>3</sup> showed that the average length of stay for those aged 65-and-over to be 14.4 days, and for persons age 75 and older 15.8 days, compared with 7.6 days per person under age 65. Even with the advent of compulsory utilization review committees, the situation has been static. The physician is usually faced with the dilemma of trying to discharge a patient who is not acutely ill and no longer needs the care of the



acute hospital, but is still too ill to return home and to the community. The extended care facility has been looked at (and rightfully so) as at least a partial answer to this problem.

Aside from these overtly contributing problems, there has been an obvious reticence on the part of the family physician to become involved with geriatric patients and their inherent problems. Physicians all too often see the elderly patient as a time consuming, necessary evil of their practice and have a tendency to treat them as complaining individuals who are hopeless. This attitude is, of course, often perceived by the patient and compounds the problem. The treatment goals for the geriatric patient should be to achieve physical, emotional, and social rehabilitation, to minimize disability and to teach the patient to live with a possible residual disability. It is the responsibility of the physician to inculcate in his patient the attitude that the passage of years may lead to changes, but does not mean that he will be a physical and emotional cripple. He must be prepared to discover asymptomatic disease and explore the ideal health standards in the condition of his patient. Much of the physical examination should be used to estimate the patient's ability in terms of the *percentage of optimum function* which can be obtained.

From the patient's point of view, the term "golden age" too often is a synonym for a depressing and anxious period of life. This stage of development is characterized not only by his own physical illnesses but, more importantly, by loss of friends due to illness or death, isolation, and often rejection by his own family—not to mention his own physician. To compound this, the family has difficulty in dealing with their own feelings toward their parents. They are often caught in a web of guilt over not being able to handle the elderly patient and anger over the financial and emotional drain placed upon them.

Most patients entering an extended care facility must deal with all these factors and look to the facility as their last hope for any return to normal functioning. These problems, together with a sort of confusion among many physicians as to just what an extended care facility is or should be, often lead to many anxious moments on the part

of the family, physician, patient and community.

### What Are Extended Care Facilities?

As a general rule, these facilities are considered as extensions of the hospital which are licensed as nursing homes. They may be part of a hospital, or in close enough proximity to a general hospital to have a transfer agreement. Patients eligible for admission to these units must be covered by Medicare and have to be in a hospital for three days prior to transfer to the facility. Patients must either be transferred directly from the hospital or from home; but, if coming from home, they must not be out of the hospital longer than 14 days.

### Criteria For Admission

The principal diagnostic categories of patients admitted to the extended care unit may be the following:

1. Cardiac patients in the convalescent phase of congestive heart failure, as well as those with acute convalescent myocardial infarction, resolving pericarditis and heart block;
2. Neurologic patients who have suffered cerebral vascular accidents and have residual paresis, aphasia, or neuropathy of diverse etiology;
3. Orthopedic patients with post-traumatic fractures, amputations, arthritis and conditions requiring prolonged traction;
4. Patients with metabolic disorders—diabetes mellitus, renal failure and hyperthyroidism requiring supervision of diet and medication;
5. Patients convalescing after surgery for a variety of conditions;
6. Selective patients with neoplasms who are undergoing active therapy.

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**Marshall A. Falk, M.D.,** is Medical Director of the Fox River Rehabilitation Center, as well as Assistant Professor of Psychiatry, The Chicago Medical School. A graduate of The Chicago Medical School, Dr. Falk is a member of the Illinois Psychiatric Society, the American Academy of Psychosomatic Medicine and the American Academy of Geriatrics.



Obviously no list can be complete, but the general rule to be followed is that patients must have at least a partially reversible condition or one that needs to be stabilized. This general rule has inherent in it two basic premises:

1. That all patients prior to admission must be screened because all patients in a general hospital over the age of 65 are not candidates for extended care facilities;
2. That even though the law states that a patient is covered *up to* 100 days in an extended care unit, the patient should be discharged as soon as he has received maximum benefit from the institution. This, of course, is a determination which should be made primarily by the patient's physician.

### **Extended Care Staff**

The number and type of staff will vary from institution to institution, and from community to community, but in general, there are certain characteristics of a staff that are important in giving good patient care.

First of all, the staff orientation should be one where it is expected that patients will improve. It is important that staff realize that their patients may not reach 100% function, but that they will gain some percentage of function. With proper screening of patients and good care on the part of the staff, improving patients will be a common occurrence.

Secondly, frequent conferences of the staff must be held not only for general education purposes, but also to allow them to vent feelings about geriatric patients and to correct distortions. Thirdly, the staff should be allowed to participate in screening of patients for admission and determination of utilization of beds. Finally, besides adequate medical coverage in the form of nurses and physicians, an active staff of qualified physical therapists, occupational therapists and volunteers should be used to keep the patients active.

### **Specific Problem Solutions**

The average practicing physician usually finds he does not have enough time to spend with his patients as he would like. On the other hand, to give good patient care, i.e., to get results that are both satisfying to physician and patient, several sug-

gestions might be helpful:

1. The physician should spend 10-15 minutes, a minimum of once a week, with his patients. This will allow the patients to unburden some of their fears and, at the same time, shows the patients that their physician is interested in them. Frequently, the patients express to the staff that they must be hopeless because their physician doesn't visit them and, therefore, is not interested in them anymore;
2. Medication for the anxiety and depression which accompanies all physical illnesses of the geriatric patient to a greater or lesser extent should be prescribed and discussed with the patient;
3. Realistic goals such as ultimate walking with a cane or walker and where the patient will go after discharge should be discussed with the patient. A patient should never be told he will walk "as good as new" if it is not in the realm of possibilities;
4. It is up to the physician to keep the nursing staff informed verbally, by written orders and progress notes, what he expects for his patient and what effect the anxiety and depression has on his patient's somatic illness. He should be specific as to how he wants the staff to react to his patient.
5. The family must be kept abreast of the patient's progress by the physician and must be involved in the patient's care. This can be done easily by taking the time to explain to them what medical and psychologic problems the patient has and how they can help. Above all, their attitude must be one of expecting the patient to improve—not necessarily to be cured.

### **Nursing Staff**

In treating the elderly patient, the nursing staff must keep in mind that with aging, individual behavior patterns become more intensified. Any change is difficult for the patient to adjust to. On admission, the patient is examined, questioned, stuck with hypodermic needles, separated from his loved ones, and often given a room further from the bathroom than his bladder cares to be. An explanation on the part of the nursing staff often helps soften the blow. All staff should endeavor to reduce the number of changes a patient has to meet.



Many are not essential to patient recovery. Rigid insistence on non-essential routines achieves negative results, patient irritation, staff frustration and pitched battles in many areas. Since the patient has more at stake—his right of control—he usually wins such contests. The nurse may exhaust her temper, fall into the insidious practice of lumping him in the uncooperative category or—worse still—if she triumphs, she will produce yet another disciplined oldster convinced that he can decide nothing for himself.

Patients, regardless of disability, must be encouraged to do as much for themselves as possible. Bringing a patient a glass of water, which he could easily reach himself, is hardly preparation for returning to the community. Families may object to their loved ones not being waited upon, but usually explanations in the form of orientation of both patient and family at time of admission can alleviate many future problems.

Family

Most discussions about doctor/patient relationships do not deal with the most important factor which affects both the doctor and patient—the family. This is particularly pertinent to the geriatric patient. The family must be informed of the physician's goals, problems, the nursing staff's goals, and must be involved in formulating future treatment.

More importantly, the family must be allowed to ventilate to the physician, nurse, social worker, administrator or other interested party about their problems in relation to the patient. The family's guilt over not being able to adequately care for their parents and their anger over the financial and emotional drain and demands on them must be brought to the surface. The family, like the patient, must be reassured.

Community Agencies

The facilities available to the geriatric patient must be explored with the patient and family. Often these are in the form of recreational opportunities available after discharge, visiting nurse associations, home care domestic helpers and a variety of other community services. All of these must be explored with the family in preparation for the patient's discharge.

These ancillary aids can, when appropriate, be used while the patient is still in the extended care unit. The patient must be involved in activities as much as possible and not left to vegetate. This is particularly true for weekends and evenings when any strange institution can be particularly lonely and frightening. The form that this recreation takes can be simple and inexpensive. For example, even a bed-ridden patient can watch a movie, play bingo or be part of a group discussion. The leaders for these activities can usually be easily obtained from the community in the form of volunteers.

Results

The experience of one extended care Medicare facility will be described briefly. The results given, we feel, are reproducible anywhere. It doesn't take a special type of physician or a very sophisticated staff to obtain good results, but rather a change of many present attitudes on the part of all those concerned with the treatment of the geriatric patient.

Fox River Rehabilitation Center and Extended Care Facility is a 74-bed, non-profit institution serving Chicago's north side. In the first 18 months of operation under Medicare (January, 1967 to July, 1968), 1,231 patients were admitted with an average length of stay of 26.7 days.

Table I  
Diagnostic Categories of Medicare Patients

Diagnosis	Percentage
Cardiac .....	20%
Orthopedic .....	20%
Neurologic .....	25%
Pulmonary .....	10%
Post-Operative .....	25%
	100%

Table II  
Age Range of Medicare Patients

Age Range	Number Admitted
65-69 .....	281
70-79 .....	684
80-89 .....	250
90 & Over .....	16
	1,231

Table III  
Disposition of Extended Care Patients

Disposition	Percentage
Able to Return Home .....	75%
Placed in Nursing Home .....	10%
Returned to General Hospital .....	14%
Death Rate .....	1%
	100%

## Conclusions

Physicians must understand what extended care facilities are and how they can be used to help not only the patient, but the physician. From the physician's point of view, he can release acute hospital beds and, therefore, treat more patients efficiently. At the same time, the patient can often be returned as a functioning member of the community.

The care of the geriatric patient up until this time has been viewed by most physicians as an uninspiring, unrewarding and, at times, unwanted experience. This is due to many factors, not the least of which are the emotional reactions of the patient, family and physician. The patient becomes anxious and depressed, the family guilty and angry and the physician overwhelmed. The time has come for physicians to re-evaluate their attitudes toward the elderly patient and realize that many of the pa-

tients in the 65 and over age group, although not curable, can improve.

The staffs of extended care facilities, as well as community agencies and facilities, are integral parts of the treatment modalities of the geriatric patient. The doctor, be he family physician or surgeon, if he is involved in care of the geriatric patient is the captain of the team. In this capacity he must coordinate all those factors which he can to improve patient care.\* ◀

\*This paper was prompted by questions which were posed at the exhibit displayed at the Illinois State Medical Society meeting from May 20 to May 22, 1968. The exhibit, entitled "Extended Care Programs on the Community Level," was a Silver Prize Winner at the meeting.

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## Clinics for Crippled Children Scheduled

Twenty six clinics for Illinois' physically handicapped children have been scheduled for October by the University of Illinois, Division of Services for Crippled Children. The Division will count 20 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing service. There will be four special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

Oct. 1 Hinsdale—Hinsdale Sanitarium  
Oct. 1 Rock Island, Cerebral Palsy—3808 Eighth Avenue  
Oct. 1 Metropolis—Massac Memorial Hospital  
Oct. 2 Cairo—Public Health Building  
Oct. 2 Lake County, Cardiac—Victory Memorial Hospital  
Oct. 7 Carrollton—Boyd Memorial Hospital  
Oct. 8 Champaign - Urbana — McKinley Hospital

Oct. 9 Springfield, General — St. John's Hospital  
Oct. 9 Macomb — McDonough District Hospital  
Oct. 9 Rockford—St. Anthony Hospital  
Oct. 10 Chicago Heights, Cardiac — St. James Hospital  
Oct. 10 Evanston—St. Francis Hospital  
Oct. 14 Quincy—St. Mary's Hospital  
Oct. 14 East St. Louis—Christian Welfare Hospital  
Oct. 14 Peoria, General—Children's Hospital  
Oct. 15 Mt. Vernon—Good Samaritan Hospital  
Oct. 15 Chicago Heights, General — St. James Hospital  
Oct. 16 Elmhurst, Cardiac—Memorial Hospital of DuPage County  
Oct. 24 Chicago Heights, Cardiac — St. James Hospital  
Oct. 28 Belleville—St. Elizabeth's Hospital  
Oct. 28 Peoria, General—Children's Hospital  
Oct. 29 Springfield, Cerebral Palsy—Diocesan Center  
Oct. 29 Aurora—Copley Memorial Hospital  
Oct. 29 Centralia—St. Mary's Hospital  
Oct. 30 Bloomington—St. Joseph's Hospital  
Oct. 30 Flora—Clay County Hospital



## An Interview

# SAMA Viewpoints Explored

By LAUREN BARNETT

In addressing the 1969 ISMS House of Delegates, Bruce G. Fogel, University of Illinois medical student and Notional Treasurer of the Student American Medical Association, bestirred many physicians in the audience. Many may have been distracted by the speaker's strong language—to the point where they missed his message.

In an effort to clarify this message, and attempt to clear up misunderstandings regarding radicalism and activism among today's medical students, the following article was suggested by the ISMS Advisory Committee to the Student American Medical Association which believes that the members of the Illinois State Medical Society should be interested in the activities and interests of their colleagues of tomorrow.

**Q. As national treasurer of SAMA, Mr. Fogel, would you first explain to us exactly what the Student American Medical Association is?**

A. The Student American Medical Association (SAMA) is an independent student professional organization with 24,000 active medical student members in nearly 100 medical schools throughout the country and 35,000 intern and resident affiliate members.

**Q. In light of the recent events and demonstrations by students which occurred during the AMA Convention in New York this July, can you tell us about the students who are involved in this movement and what they represent?**

A. The group that staged the New York demonstration represented no single organization. They were very well organized with bull horns, bail money, radio contact with their outside demonstrators, people placed at strategic microphones and so forth. Yet, they came with no specifically formulated policy, nor any constructive proposals. They came to make their statement, which they were allowed to do, and leave. They expected to be met with physi-

cal violence, but disappointingly for their own cause, were not.

**Q. During the New York Convention, we frequently heard the terms "student radicals" and "student activists" used. Are these terms interchangeable? If not, what's the difference?**

A. No. These are two very different groups. The student radicals in the health professions represent no real organization any more. The student "activists" who are not necessarily "liberal" (many of them are very conservative in their philosophies) are termed "activists" because they are involved and committed to what's happening now.

Unlike the "student radicals" who feel that the necessary changes in the health care system cannot be brought about through the channels provided for in the present structure of organized medicine, the student activists participate because they believe that change can occur within the present system and want to become involved in bringing about improvements.

Just about all medical students today are concerned about problems in health

care no matter what their political label may be. The concern is extremely widespread. The type of actions precipitated by this concern is what separates these two groups.

**Q. Which of these two groups is represented by SAMA?**

A. The "student activists," definitely. I don't mean to say that all members of SAMA agree on the exact steps to be taken on each and every problem, or that there are no student radicals among SAMA members. However, through the constructive and far-reaching programs which SAMA has initiated (to try to improve medical education and health care) the student activist is able to voice his concern and become actively involved in finding solutions to problems.

**Q. What in your opinion has precipitated this "great concern" on the part of students today?**

A. Well, for one thing, the tremendous technological achievements which have taken place in recent years. When the United States can put a man on the moon, the fact that some children in this country are starving emphasizes a tremendous disparity to the youth of America. All students feel that there are things in our society which are great, but these things also serve to point up our shortcomings. The point is that we can solve tremendous problems when we want to and we know it.

**Q. Students are often criticized for overlooking that which is good in America. Do you think this criticism is justified?**

A. No. I do agree that we often tend to overlook, or perhaps take these things for granted. However, it's the same thing as when a patient comes to see his physician. The physician does not extol him on how great he looks and the things that are fine with him. The physician has an obligation to find out what's *wrong* with him. Accordingly, as students in the health professions, we are primarily concerned with those who are not receiving adequate health care.

**Q. What do medical students feel is the biggest problem in the health care field today?**

A. Regardless of how many people in the U.S. are getting adequate or even excellent medical care, there is a small segment that is getting poor care-or no care at all. Medi-

cal students today are primarily concerned with patients, and "patient-care." This is why medical students have, for the first time, become involved themselves. Medical students are already functioning where the real problems are. It has long been recognized that there are problems of inadequate health care in Appalachia, the ghetto and in specific segments of our population. These are just a few of the areas in which students want to see a more concerted effort toward better health care taking place.

**Q. Don't you feel that other generations of physicians have acutely felt a need for improvements in some of these same areas?**

A. Yes, of course. However, students today are actively entering these areas and trying to solve these problems. We recognize that this is going to be a very difficult and current problem for a long time to come. But students are making a commitment now, and in all likelihood will maintain their commitment.

A great many physicians have pointed out to us that they are as concerned as students with the same problems. Nevertheless, I feel that the difference today is that medical students are already doing something about it, as students, and therefore show an early indication of a long range commitment on their part.

**Q. Some medical student organizations have been accused of losing sight of their commitments, of placing more emphasis on their politics than on their health care efforts. Have SAMA's efforts taken this route also?**

A. No. SAMA members generally feel that we have gone the route of creating responsible programs which are designed to demonstrate a problem, involve medical students in the problem, and attempt to begin a solution which will reduce and eventually solve the problem. A good example of this is the year-round community health project which SAMA has begun in Kansas City. In the program, the commitment which is made during the summer is not suddenly given up during the year.

**Q. Could you enumerate on some of the other projects in which SAMA has become involved?**

A. One good example would be our project in Appalachia. Although this area is by no means a ghetto, it does provide us with



an entirely new set of challenges in the health care field which are not being met today. There, the problems are not overcrowding and air pollution, but instead lie in the areas of education, ignorance and years of traditional neglect.

This summer SAMA has gone into Appalachia with 100 medical students and 40 nursing students, for a 10-week summer program in which students are becoming involved, seeing where the problems are. They are learning about people and are beginning to formulate ideas about how to solve these problems.

**Q. With all the criticisms being waged at the medical schools today, what's SAMA doing in the area of medical education?**

A. This is another area in which SAMA, unlike other organizations, is not just going in and making a statement as to what's wrong and leaving. We are attempting to become involved on every real level. We are becoming involved in projects which are actually changing medical education and making it better.

We organized the First National Student Conference on Medical Education last February which was held in conjunction with the AMA Congress on Medical Education. Over 300 medical students from all over the U.S., representing 85 medical schools, met here in Chicago to discuss problems of medical education. We talked about how to do something other than complain about our education, and how to change it and make it better and more worthwhile.

SAMA has also set up the First National Student Commission on Medical Education, to study medical education in depth.

We also have set up an Institute for the Study of Health Care in Society, located in Washington, D.C., where numerous agencies and offices which affect the delivery of health care are located. In this program, 50 medical students are actually studying how health care is really being delivered in the U.S., what are the problems and their ramifications, and what agencies have an effect on these programs.

**Q. Since physicians and medical students are both concerned with the delivery of the health care system in this country, what do you think is the cause of the communications gap which seems**

**to exist between these two groups?**

A. It seems to me that this "student-physician gap" is not simply a matter of age, in fact I feel that it completely transcends age. It is more a gap between experiences and background. The difference occurs because today's physician experienced times and situations in this nation about which most medical students have only read. Taking into account the fact that most students are under 25 years of age, the two groups were trained during entirely different times and entirely different circumstances. Although our backgrounds may be different, to claim that our concerns are different is ridiculous.

**Q. Can you cite an example of students becoming more involved with physicians through SAMA?**

A. Yes. The Illinois Medical Student Summer Job-Education Project has provided the opportunity for 71 medical students to become directly involved with practicing physicians in community hospitals.

**Q. What is the result of this physician-student contact?**

A. Both groups have not only worked out solutions to their common problems and sources of friction, but both groups have seen that they each are really suffering from the other's image in the public press. SAMA members have found that when the two groups get together, they find that they both share a great deal more common concerns than their difference would indicate.

**Q. How does the SAMA Sustaining Physician Membership aid in reducing this gap?**

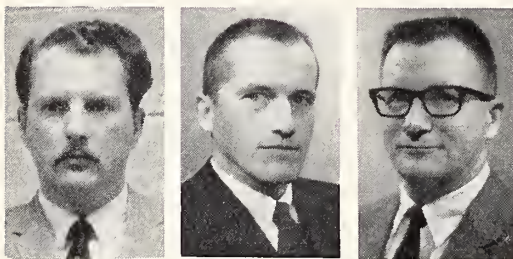
A. Now that medical students in Illinois will have the opportunity of serving ISMS committees, it is important that the practicing physician understand what SAMA is doing and why. As a sustaining member of SAMA, physicians would receive the same information and publications as medical students. This would complete the exchange of information and ideas that has been begun by the Illinois State Medical Society. ◀

If a physician is interested in obtaining a status of sustaining member, please write:

SAMA Advisory Committee  
Illinois State Medical Society  
360 N. Michigan Ave.  
Chicago, 60601

# Water Related Tularemia Cases In Illinois

BY LEWIS W. STAHL, PAUL R. SCHNURRENBERGER, D.V.M., M.P.H.,  
AND RUSSELL J. MARTIN, D.V.M., M.P.H./SPRINGFIELD



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*Tularemia in man is best known as a disease contracted from infected rabbits. For years it was thought that the rabbit was the only source of tularemia as evidenced by its synonym, rabbit fever. Epidemiological investigations and research of the past decade have suggested a number of other potential sources. The list of animals that have been found infected and have transmitted the disease to man has been expanded until it now includes a variety of mammals, both wild and domestic: birds, including pheasant, grouse, and quail; and arthropods, such as the deer fly and ticks.<sup>1-4</sup> More recently, the muskrat (*Ondatra zibethicus*) has been implicated in tularemia outbreaks.<sup>5</sup> Epidemiological investigations also indicate contaminated water can serve as a vehicle for transmission of the tularemia organism.<sup>6</sup>*

*This paper describes two tularemia cases in which the exposure was water related. To our knowledge, this includes the **first reported case** of tularemia in which a Canada goose (*Branta canadensis*) was implicated as the probable source. There is one report of an agglutination reaction found in a mallard (*Anas platyrhynchos*)<sup>6</sup> but the authors are aware of only one report where *Francisella tularensis* was isolated from waterfowl, that being from a Franklin's gull (*Larus pipixcan*).<sup>7</sup>*



**CASE 1.** On November 20, 1967, a 24-year-old, white, male resident of Morgan County experienced an ulcerous lesion on the top of his right middle finger. The illness progressed to fever, chills, and enlargement of the antecubital and axillary nodes. He was hospitalized for one week beginning December 1, and responded to antibiotic therapy. Serum samples collected on December 1 and December 27 were reactive by agglutination test at dilutions of 1:160 and 1:640 respectively.

The patient denied recent tick contact but related the following exposure to wild animals during the 14 days prior to onset:

1 day prior—dressed 10 wild ducks and  
2 Canada geese

4 days prior—dressed 1 muskrat

11-14 days prior—dressed 1 deer and several squirrels

All the animals were normal in action and appearance. From the exposure dates, the muskrat would seem the most probable source, followed by the ducks and geese.

**CASE 2.** This case occurred in Mrs. X, a 53-year-old, white, housewife from Marion County. The initial signs—high fever, chills, convulsions, and an ulcerous lesion at the base of the left thumb nail—appeared November 17, 1967. Within 24 hours, the axillary lymph nodes had become quite enlarged, the fever subsided, and the patient began to experience general malaise. The patient responded quite well to treatment with streptomycin and demethylchlortetracycline, though the malaise continued for some two months. A blood sample taken November 18, was negative for tularemia by agglutination test. Samples of blood collected from the patient on November 28, and January 19 were reactive for tularemia at titers of 1:80 and 1:2560 respectively. *Brucella* agglutination tests on the three samples were non-reactive.

On November 11, 1967, Mr. X had shot two Canada geese which seemed to be mates, the rest of the flock having continued their flight. Goose number 1, which was apparently normal, was shot upon attempting to fly from the pond. Goose number 2 was shot through the head while still on the water, apparently unable to fly. Mr. X took both geese home, plucked them, and cut off the heads and feet. Mrs. X had a history of hangnails and recalled having a hangnail on her left thumb on the day

she cleaned the birds. She removed the viscera with her left hand. The viscera of bird number 1, the bird shot in flight, appeared normal. The liver was firm and brown. The gall bladder was still attached. The crop and gizzard contained clover and fine sand. Clover was growing near the pond and a fine sand lined the pond. By contrast, the liver from bird number 2 (the bird that did not fly) was so friable that it fell apart when handled. She further described the liver as very smooth, non-ulcerated and light orange-brown. She did not find the gall bladder or any evidence of food, sand or gravel in the crop or gizzard.

The birds then were placed in plastic sacks and frozen. After her illness they were removed from the freezer and buried. They were recovered January 22, 1968, and sent to the USPHS Plague Laboratory in San Francisco, California, where culture attempts and antigen precipitation studies were negative for *F. tularensis*. The birds had been frozen, thawed, and re-frozen at least three times between the date they were shot and their receipt at the laboratory. These temperature changes would not be conducive to survival of the organism.

Mrs. X has an exceedingly intense fear of handling rabbits as she witnessed the death of a close relative from tularemia in the 1930's. On November 12, a young rabbit, not over a pound and a half in weight, was captured by one of two hunting dogs kept by her husband. Mr. X dressed the rabbit and Mrs. X claimed that at no time did she touch the rabbit, or the possibly contaminated utensils which had contacted the rabbit. The rabbit was discarded after her illness and could not be retrieved for testing. It is discounted as the source of infection on two bases: (1) intense fear of the rabbit by Mrs. X and her refusal to have contact with it; and (2) her husband's exposure to the rabbit and his failure to develop the disease. Mrs. X further denied any insect bites or contact with the hunting dogs within the known incubation period for tularemia. Her personal opinion was that she had contracted it from the goose.

This report discusses two cases of tularemia, whose probable sources were vertebrates with an aquatic habitat. Muskrats have previously been implicated in numerous tularemia outbreaks,<sup>5</sup> but this is the first implication of migratory waterfowl as

(Continued on page 309)

# Meeting Memos

## **Sept. 17—ISMS President's Tour**

11th District  
Elmhurst Country Club, Wood Dale

## **Sept. 19-20—Illinois State Society of Radiologic Technologists**

*34th Annual Meeting*  
Augustine's Motor Lodge, Belleville

## **Sept. 21-25—World Committee for Comparative Leukemia Research & World Health Organization**

*4th Intl. Symposium on Comparative Leukemia Research*  
Cherry Hill Inn  
Cherry Hill, New Jersey

## **Sept. 22-23—Iowa State University**

*11th Annual Midwest Interprofessional Seminar On Diseases Common To Animals & Man*  
Memorial Union, Iowa State University  
Ames, Iowa

## **Sept. 25—ISMS President's Tour**

2nd District  
Holiday Inn, Peru

## **Sept. 25-27—Chicago Committee on Trauma of The American College of Surgeons**

*Postgraduate Course for Emergency Room Nurses*  
Palmer House, Chicago

## **Sept. 26-Oct. 3—American Academy of General Practice**

*21st Annual Convention*  
Philadelphia, Pennsylvania

## **Oct. 3—Chicago Surgical Society**

*41st Annual Dean Bevan Lecture*  
University of Chicago Club, Chicago

## **Oct. 6—Disease Detection Information Bureau**

*Symposium*  
Elkhart, Indiana

## **Oct. 6-10—American College of Surgeons**

*Annual Meeting*  
Fairmont Hotel, San Francisco, California

## **Oct. 8-11—National Hemophilia Foundation**

Drake Hotel, Chicago

## **Oct. 9—ISMS President's Tour**

8th District  
Champaign Country Club, Champaign

## **Oct. 9-12—Association of American Physicians & Surgeons**

*26th Annual Meeting*  
The Brown-Palace Hotel  
Denver, Colorado

## **Oct. 9-10—Eye Bank Association of America**

Sheraton Blackstone Hotel, Chicago

## **Oct. 10-11—American Society of Ophthalmologic and Otolaryngologic Allergy**

Palmer House, Chicago

## **Oct. 11-12—American Association of Ophthalmology**

Palmer House, Chicago

## **Oct. 12-16—American Society of Plastic & Reconstructive Surgeons**

Chase-Park Plaza, St. Louis, Mo.

## **Oct. 12-17—American Academy of Ophthalmology & Otolaryngology**

Palmer House, Chicago

## **Oct. 15—Kidney Foundation of Illinois, Inc.**

*5th Annual Symposium on Recent Advances in Renal Disease*  
Grand Ballroom, LaSalle Hotel, Chicago

## **Oct. 16—ISMS President's Tour**

6th District  
Holiday Inn, Quincy

## **Oct. 17—The Chicago Gynecological Society**

Drake Hotel, Chicago

## **Oct. 18-23—American Academy of Pediatrics**

Palmer House, Chicago

## **Oct. 22—ISMS President's Tour**

1st District  
Pheasant Run, St. Charles

## **Nov. 3-5 & 10-12—Mayo Clinic**

*Clinical Reviews*  
Rochester, Minnesota

*The worst jolt most of us ever get is when we fall back on our own resources.*  
—Frank McKinney Hubbard



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## Donors Can Give Blood Until Their 66th Birthday

Americans in good health can be blood donors now until their 66th birthday instead of the 60th or 61st as in the past.

A joint announcement of this liberalization of medical standards for blood was made recently by the American Association of Blood Banks and by the American National Red Cross in Washington, D.C. The two organizations together collect and process 90% of the more than 6,500,000 pints of blood used annually for surgery and therapy in U.S. hospitals.

"This extension of the eligible age limit for blood donors is in recognition of two facts," explained Dr. Frank Coleman of Tampa, Florida, President of the Association. "First, that the need for blood is constantly increasing at a rate of about 12%

annually. Second, that, thanks to better medical care, better nutrition and other factors, Americans are living longer and also keeping their health and vigor longer than in the past."

Donors 66 years of age or over, under the new AABB and ARC policies, may continue to give blood if they obtain the written consent of their personal physician on the day of donation.

Donors must be in good health, have normal temperature, pulse and blood pressure, and meet the other requirements for blood donors. Individuals should check with their local community or hospital blood bank or Red Cross blood center relative to their eligibility to give blood.

## CMS RELATIONSHIPS

Operational procedures were finalized for two four-man committees, consisting of downstate members of the ISMS Board of Trustees to meet with an equal number of representatives of the Chicago Medical Society. The first committee will discuss proportional representation from CMS in the House of Delegates and on the Board of Trustees. The second committee will discuss the possible merger of the CMS Clinical Conference and the ISMS Annual Scientific Session. Dr. Frank J. Jirka, Jr., Chairman of the ISMS Board of Trustees, will preside at these meetings, without vote.

Members of the respective committees are:

Chicago Medical Society; Drs. William Adams, Andrew Brislen, Maurice Hoeltgen, Fred Tworoger (same committee to be used for both purposes).

Illinois State Medical Society; Committee on Representation—Drs. Arthur Goodyear, Joseph O'Donnell, William McNichols, Jr., Willard Scrivner—Committee on Annual Meeting—Drs. Darrell Trumpe, Mather Pfeiffenberger, Joseph Bordenave, Paul Youngberg.

## COMMITTEE TO ACTIVATE PEER REVIEW

Upon recommendation of the Executive Committee, the Committee on Prepayment Plans and Organizations was directed to activate an effective peer review mechanism within the Society. Also, to consider the practicality and possible methods of implementing requests from IDPA and the Health Department, Blue Cross-Blue Shield and Continental Casualty Company for projects requiring peer review. Peer review primarily for the purpose of adjudicating fee disputes with government and third-party programs has been an established society function for many years. These programs are now requesting added emphasis on peer review as applied to utilization of services.

## CITIZENS COMMITTEE DISCUSSED

The possibility of forming a Citizens Committee to support a drive to produce and retain more doctors in Illinois and to increase the supply in medically deprived areas was discussed. The Board was advised that the Executive Committee earlier took no action on a proposal to employ an advertising and public relations firm for this purpose. Staff was directed to explore the possibility in greater detail. Financing for special projects to aid and encourage the medical schools to turn out more graduates, promotion of internships and residencies downstate and other recommendations contained in the Board of Higher Education study, were made available by action of the 1969 House of Delegates.

## MEMBERSHIP SURVEY

Upon recommendation of the Public Relations Committee, an opinion survey of the membership during 1969 was authorized. A similar survey was conducted in 1968. Preliminary approval was given to the questions on the survey, with final approval to be granted by the Executive Committee.



## PHYSICIAN ASSOCIATION PRESENTS REPORT

The Board heard a report by Dr. Robert J. Baker, president, and Mr. William B. Sale, administrator, Associated Physicians of Cook County Hospital, outlining the accomplishments, purposes, problems, and future plans of their organization.

Subsequent to receiving the report and asking specific questions, the Board, in Executive Session, adopted the following statement:

"We received with favor the report of Dr. Baker, but the complicated interrelated processes of medical education and delivery of medical services, and the role of third party agencies, is such that we cannot arrive at a conclusion at this time, and therefore take the matter under advisement."

## MISCELLANEOUS

In other actions the Board voted to approve:

1. ISMS membership in a reconstituted Ad Hoc Emergency Medical Services Study Commission,
2. Publication of two pamphlets entitled, "Physician Spare That Emergency Room" and "Is This Trip Necessary?" developed by the ISMS Hospital Relations Committee,
3. The revised printing of the 1963 Relative Value Study due to unsolicited demands,
4. Distribution of the Committee on Aging's 13-part television series, "The Time of Your Life" to industry, church groups, and other organizations on a sale or rental basis,
5. Regularly scheduled quarterly meetings between the Executive Committees of ISMS and the Illinois Hospital Association,
6. A request to AMA or possible submission of a resolution at the AMA Annual Meeting calling for a delay in the approval of the revised standards of the Joint Commission on Hospital Accreditation—scheduled for approval August 9,
7. An immediate protest to AMA, Secretary of HEW, and Illinois Congressional Delegation if adverse regulations are issued by the Federal government under Medicaid as rumored,
8. A 10% increase in the Illinois Medical Journal black and white advertising rate.

## OCTOBER BOARD MEETING

The next meeting of the Board will be held in Peoria on October 11 and 12.

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We have found that many physically handicapped people have exceptional perseverance. Their strong will to succeed provides job opportunity for them as it would for anyone. We will continue to need and use their skills. . .  
G. L. Phillippe, chairman of the board,  
General Electric Company.

Out of more than six million home loans guaranteed for veterans by the Veterans Administration, 48 per cent have been repaid in full. Only three per cent of the \$67.1 billion in loans have resulted in claims against VA, and much of the money outstanding on the defaulted loans is still recoverable through tangible property.

when it's late in life  
and anxiety  
and depression  
coexist...

initial therapy

**Triavil<sup>®</sup> 4-10**

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amitriptyline hydrochloride

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amitriptyline hydrochloride.

appropriate  
therapy in an  
appropriate  
dosage







THE EMERGING REPUBLICAN MAJORITY, Kevin Phillips, Arlington House, 1969. \$7.95.

THE EMERGING REPUBLICAN MAJORITY is more than a penetrating analysis of how America votes. In showing the reader why Americans vote the way they do, the author gives an interesting and often amusing historical tour of the nation. Kevin Phillips maintains that America is not a melting pot. "For a century, the prevailing cleavages in American voting behavior have been ethnic and cultural. Politically, at least, the United States has not been a very effective melting pot. In practically every state and region, ethnic and cultural animosities and divisions exceed all other factors in explaining party choice and identification." Phillips contends that an accurate vote profile requires a map of each state's *ethnic* population. "Thus," he adds, "what seems like uselessly remote historical data—the details of the people of the United States—is actually quite vital to understanding the dynamics of the upcoming political cycle."

Having researched and compiled this multitude of maps and charts, Phillips projects the Republican future: "This new era will be increasingly Republican and increasingly conservative. The long-range meaning of the political upheaval of 1968 rests on the Republican opportunity to fashion a majority among the 57% of the American electorate which voted to eject the Democratic Party from national power." THE EMERGING REPUBLICAN MAJORITY tells how that can be accomplished with an unchallengeable array of facts about how the electorate has voted in past elections, why they voted a certain way, and why they are changing their vote patterns today.

Washington columnist Clayton Fritchey stated: "The (book) ought to go a long way toward explaining why President Nixon is gradually inching to the right, but it would horrify and dismay Mr. Nixon's great patron, former President Dwight D.

Eisenhower.

"To put it bluntly, Phillips says success lies in forgetting about Negroes, Ivy Leaguers, Eastern 'establishment' Republicans and similar types concentrated in the big cities and fashionable suburbs. He would go for white segregationists, Bible belt fundamentalists, the simple folk of rural and small-town America and the newly emerging middle class that is crowding into mass suburbia. He also sees opportunities of capitalizing on Irish Catholic prejudices.

"In combination, he thinks this adds up to a solid majority. Whether or not this is so, it is a conscious polarization that would have shocked Eisenhower, who was nominated over Robert Taft by the Eastern establishment Republicans and elected overwhelmingly by appealing strongly to all elements of the American public."

The Phillips strategy presupposes that Nixon follows through on his conservative campaign. If not, Phillips discerns a real test, and Nixon could then be expected to lose votes to somebody in or outside the Republican Party who addresses himself to the concerns of the conservatives.

Kevin Phillips was an assistant to Nixon's campaign manager, Attorney General John N. Mitchell. Though right-of-center, he cannot be described as an orthodox conservative. His views of many issues (e.g. *laissez-faire*, Joe McCarthy, the deep South) are not those of most conservatives. Similarly, he criticizes the Goldwater campaign for what he considers basic errors of strategy, even though he acknowledges the importance of 1964 in breaking the Republican Party from its liberal moorings. The impact of the book is strengthened because the author is not a conventional conservative, but rather a specialist in *winning* vote patterns. Kevin Phillips has thus written a landmark book, one which promises to be the political bible of the new era it heralds. He has shown Republicans, and conservatives, their opportunity.

*Read an interesting book lately? Write us a note and suggest its inclusion in the Public Affairs Library—Reviews. The Library appreciates your comments and suggestions.*



## ISMS Supports IMAA

BY SANDRA BREDTHAUER, CMA/ELGIN

At the May annual meeting of the Illinois State Medical Society, the following resolution was presented to the House of Delegates—and unanimously passed by that governing body.

**WHEREAS**, physicians are delegating a greater number of technical assignments to their medical assistants because of increasing demands from complicated government health programs and other professional responsibilities, and

**WHEREAS**, the goals of the Illinois Medical Assistants Association—non-profit, non-union, professional organization—are to inspire its members to render more efficient service to the medical profession, and to render educational service, including certification study groups and board examination, for the self-improvement of its members, and

**WHEREAS**, membership in the IMAA enables medical assistants to better serve their employers by expanding their knowledge of medical terminology, physiology, office routines and systems, examination room and laboratory techniques, and

**WHEREAS**, the IMAA has a membership of only 500 of the estimated 12,000 medical assistants in Illinois, with chapters in only 15 out of 93 counties, therefore be it

**RESOLVED** that the House of Delegates encourage county medical societies to provide leadership in the formation of IMAA chapters in their counties, and be it further

**RESOLVED** that physicians be encouraged to invest in their medical assistants by underwriting their membership dues in IMAA, and be it further

**RESOLVED** that county medical societies be encouraged to invite their chapter presidents to the meetings so that the IMAA chapter can gain a better insight into physicians' problems and take an active role in helping the county medical societies to solve these problems.

This resolution encourages county medical societies to take an active lead in organizing and supporting IMAA chapters on a local level. If you are in a county fortunate enough to already have a chapter formed, encourage your medical assistants to attend the meetings and give the chapter your support. If a chapter is not in existence in your county and your medical assistants are interested in organizing a chapter, the IMAA officers will be glad to advise you of the necessary steps.

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55,300 men, women and children died on America's highways in 1968. In addition, 4,400,000 persons were injured. Driver error, according to The Travelers Insurance Companies annual survey, was responsible for more than 80% of last year's highway casualties.

If you do a good enough screening job you may get people in your employ who are perfectly normal. But you will have screened out people who discover things like nylon. . . . Dr. Frederick Dersheimer, retired psychiatrist, E. I. duPont de Nemours, & Company.



# Truth in Lending

BY FRANK M. PFEIFER, LEGAL COUNSEL, ISMS

The Federal Truth in Lending Act, also known as the Consumers Credit Protection Act, which went into effect July 1, 1969, was enacted into law by Congress for the purpose of making known to all consumers the actual cost of all types of credit both upon a dollars and percentage basis. If any type of financing charge or interest or any other charge for delayed payment is made, the person making it must explain such extra charge in detail to all persons affected by it. If no such charge is made, the Truth in Lending Act is not involved and no explanation is necessary.

Insofar as physicians are concerned, most of them bill only for the services rendered and do not include interest or other additions for delayed or time payment in which instance the Truth in Lending Act has no application and no charge need be made by physicians following this practice.

A peculiar provision in this new Act is that if the person making the charge by agreement allows the account to be paid in more than four installments with or without a financing charge, the Truth in Lending Act comes into play. A physician not otherwise coming under the terms of the Act, but who made a practice of specifically allowing payments of an account in more than four installments, could merely stop making agreements with his patients for such installment payments. The fact that the account was paid in more than four installments would not bring the physician under the terms of the Act if he did not specifically authorize such installment payments.

Anyone coming within the terms of the Act must, in all statements or any written

communication concerning payment of a bill or fee, set out the amount of finance or time charge both in dollars and as an annual percentage rate. These two items must be listed separately on the bill and must appear in bold-faced type or in some other manner so as to be conspicuous.

A question has been raised as to the status of a physician who turns over some of his accounts to a collection agency and the agency then adds on to the bill an amount sufficient to cover the fee or charge. While this procedure is not followed in most cases and without passing on the legality of adding on such an additional charge, the indulgence in such a practice would probably bring a physician within the terms of the Truth in Lending Act. He should therefore point out to his patients in writing prior to turning the bill over to the collection agency that the charge would be added on to his bill and thus give him the opportunity to pay it within a reasonable length of time without the add-on charge for the collection agency. Any additional charge by the collecting agent would also bring the agency within the terms of the Act and therefore, any communication by the agency to the patient should contain all the necessary information.

Physicians who do not add on for time or delayed payment, who do not specifically authorize payments in more than four installments and who do not add on for the collection of the account, do not come within the terms of the Truth in Lending Act and need make no change in their billing procedures. ◀

*Ed. note: Membership Forum is a means for the ISMS physician to express opinion and viewpoint on varied topics. If you have an item you would like brought before your fellow practitioners, please submit it to Membership Forum, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601. Communications should not exceed 250 words. The right to abstract or edit is reserved. Names will be withheld upon request, but anonymous letters will not be accepted.*

## Today's Need to Defend Virtues

"In a world where many accepted standards of behavior are being challenged, we must practice as well as defend such time-honored virtues as integrity, diligence and professional excellence."—Anthony G. DeLorenzo, vice president-public relations, General Motors Corp.

# THE RESPONSE GAP





# SOCIO ECONOMIC *news*

*A service of the Public Relations and Economics Division*

By JOSEPH J. LOTHARIUS

## **ISMS President Objects To Medicare Fee Cuts**

ISMS President Dr. Edward W. Cannady has protested the action of Continental Casualty Co. (Medicare carrier) to reduce fees for all nursing home visits to the office call level. According to a recent Medicare newsletter sent to all physicians, Continental is closely scrutinizing nursing home visits and reducing payments to the level of an office call unless the physician specifically designates one visit as a house call. The company maintains that Medicare cannot allow the higher house call fee for each patient visited in a nursing home. It has been reducing all visits to the office call level, but will allow one house call charge if it is so designated by the physician. Dr. Cannady told Continental that "some thought should have been given in the drafting of appropriate regulations to cover multiple nursing home visits when the program was inaugurated."

He pointed out in his letter that ISMS is considering a request from Continental to cooperate in peer review and is attempting to establish an effective and workable mechanism. "Arbitrary actions of the nature described in your newsletter will only serve to discourage physicians from making visits to nursing homes when it is necessary to see only one patient," Dr. Cannady stated. He expressed hope that the company would modify its position on this issue.

\*\*\*\*\*

## **New Law Will Attract MDs to State**

House Bill 320, passed by the Illinois Legislature and recently signed into law by Governor Ogilvie, is an attempt to attract doctors and dentists to the state. It authorizes all counties (except Cook), cities and villages to provide medical service facilities to doctors and dentists on a lease basis. It includes land and buildings for medical or dental offices plus all furnishings and equipment required. The law provides that counties and municipalities can lease these facilities to one or more physicians or dentists and—if approved by a vote of the people—may issue general obligation bonds for the cost. The governmental unit issuing the bonds may then levy a tax to pay for them. The law states the governmental unit may lease the medical service facility under terms mutually agreed upon with consideration being given both for the need to reduce the cost and to the overall purpose of establishing and providing proper medical care in the area. All property coming within the terms of this act is exempt from local taxation.

*(Continued on page 296)*

# practice management *NEWS*

*A Service of the Public Relations and Economics Division*

## Should You Incorporate?

In 1963, the Illinois Legislature adopted the Medical Corporation Act, which allows physicians to practice medicine in Illinois as corporations. Just last month, the Internal Revenue Service withdrew its opposition to medical corporations. The IRS action makes it more important than ever for Illinois physicians to investigate the possibility of incorporating. Following are answers to some frequently-asked questions about medical corporations.

BY FRANK M. PFEIFER/ISMS LEGAL COUNSEL

### **What positions do the Internal Revenue Service and Federal Courts take on the question of medical corporations?**

Until last month, the Internal Revenue Service regarded medical corporations for income tax purposes as improper and illegal. But on August 8, 1969, the IRS dropped its fight to prevent doctors from incorporating in states—such as Illinois—where state law authorized such medical corporations.

This action is a direct result of the many favorable decisions made by the federal courts on the question of medical corporations. While the United States Supreme Court has not yet considered the issue, the federal court immediately beneath it—the United States Court of Appeals—has decided in favor of physicians and medical cor-

porations. (Perhaps the leading case is that of *U.S. vs. Empey*, 406F, 2d, 157.)

Most corporate attorneys agree that medical corporations are legal and that the U.S. Supreme Court will so hold if such a case is considered by this court.

### **Should physicians who want to incorporate wait until the U. S. Supreme Court makes a decision?**

There is no reason to wait, as it seems unlikely that the Supreme Court will overrule the Circuit Court of Appeals. Its decision is based on sound reasoning: if a state allows physicians to incorporate, this type of corporation should be treated the same as other corporations as far as income tax is concerned.

However, should the Supreme Court reverse the Circuit Court of Appeals, the phy-



sician would be in no worse position than if he had not incorporated. He would only have to pay the tax he had failed to pay because of the incorporation. He would have saved this money in the first place by not having paid it on his corporate return. **What benefits can the physician receive from a medical corporation?**

Following are five possible plans whereby physicians can receive increased benefits:

1. *Pension and Profit-Sharing*—These plans may be larger and have greater benefits than self-employed plans. The money paid into these plans is deducted from the corporate income tax as a business expense of the corporation.
2. *Salary Continuation*—The physician's widow receives a part of his salary from the corporation after his death.
3. *Deferred Compensation*—A portion of the physician's compensation from the corporation is delayed until his retirement, disability or death.
4. *Deductible Insurance Costs*—The corporation sets up disability, group life, health and accident, and medical reimbursement plans. The costs of these plans are then deducted as a corporate business expense.
5. *Stock Redemption*—A stock purchase agreement may be entered into between the corporation and its physician-members. Thus, the physician receives compensation from his stock upon retirement or death, retaining the good will and business built up over the years.

**What requirements must physicians meet before they can form a corporation?**

Only physicians licensed under the Medical Practice Act may organize a medical corporation. No one without a license can be a consultant, adviser, officer, director or shareholder. Neither can an unlicensed person own, manage or control a medical corporation. (The Medical Practice Act in no way alters the legal relationship between physician and patient.)

**How do physicians licensed under the Medical Practice Act go about forming a corporation?**

First, a physician or group of physicians would consult their accountant or tax advisor. If incorporation is desirable, they

would then contact an attorney to organize the corporation. Next, they would obtain a certificate of registration from the Illinois Department of Registration and Education. A medical corporation cannot begin business without this certificate.

**Under what names may the corporation operate?**

It may bear the last name of one or more persons formerly or currently associated with it or may adopt a name that doesn't include the surname of any present or former shareholders. The corporate name must end with one of the following: "chartered" or "limited" or the abbreviation "Ltd."; "service corporation" or the abbreviation "S.C."

**How is the price of stock shares determined for a deceased physician or a physician who no longer qualifies to own shares?**

The Articles of Incorporation or the By-Laws may set a price or a method of determining a price, which may be changed from time to time as the corporation desires. But if this is not done, then the price is the book value at the end of the month immediately preceding the physician-shareholder's death or disqualification.

**Are there additional expenses in connection with a medical corporation?**

Yes, a medical corporation—just as any other corporation—has certain expenses in connection with its formation and operation. But these expenses would not exceed a few hundred dollars each year and would in most instances be a great deal less than the monetary advantages received from incorporation.

**Should all physicians incorporate?**

Not necessarily, but each situation should be thoroughly examined. In most instances, there will be decided advantages to incorporation.

**Have we covered the entire field of medical corporations and the tax advantages by the foregoing questions and answers?**

By no means. The answers provided here are generalities and do not necessarily fit any particular set of facts. There is the possibility of many advantages to medical incorporation either by an individual practitioner or by a group. Certainly the possible advantages are great enough that they should be explored by knowledgeable accountants and attorneys. ◀

## YOUR ISMS INSURANCE QUESTIONS

**QUESTION:** *Can a member physician make voluntary additional contributions under the Society's Keogh program?*

**ANSWER:** Yes. A participant can make voluntary additional contributions for his own benefit over and above his basic contribution provided that the plan also allows employees to make similar voluntary contributions. The limits, as in the basic provisions, are 10% of the net income from the practice, or \$2,500, whichever is less. However, he cannot deduct any of his voluntary additional contribution. The advantage is that the funds will be allowed to accumulate tax free.

**QUESTION:** *What is meant by a "full-time employee" in a Keogh Act program?*

**ANSWER:** Under the Keogh Act, all full-time employees with three or more years service must be included in the plan. A full-time employee is defined as one who works at least 20 hours a week for five months of the year.

*Do you have a question of general interest on any ISMS-sponsored insurance program: Retirement Investment, Keogh, Group Disability, Group Major Medical, Professional Liability (Malpractice)? Send it to this column: "Your ISMS Insurance Questions," Illinois Medical Journal, 360 N. Michigan Avenue, Chicago, Ill. 60601. The column is a service of the ISMS Committee on Medical Economics and Insurance.*

### IRS Makes A Concession

The Internal Revenue Service last month conceded to recent federal court decisions that organizations of doctors, lawyers, and other professional people organized under state professional association acts should be treated as corporations for tax purposes. This announcement is important to ISMS members considering incorporation. For more details on this subject read "Should You Incorporate" by Frank M. Pfeifer in this issue.

\*\*\*\*\*

### MD's Eligible For Tax Refund

Illinois physicians who purchased drugs during an eight month period from August 1967, through March 1968, and paid service occupation taxes on them are eligible for a refund. The Service Occupation Tax and Service Use Tax have been declared unconstitutional by the Illinois Supreme Court. Physicians can also inform their patients who may have purchased prescription drugs during this period and paid taxes on them. All Illinois residents are also entitled to a refund if they used the services of a repairman, druggist, graphic arts supplier or tool and die maker and paid taxes for such service. Claim forms are available from any bank or can be obtained by writing Illinois Tax Refund, P. O. Box 260, Chicago 60690. Claims must be filed by December 1, 1969.

\*\*\*\*\*

### Medicare Carriers Aim Toward Uniform Performance

Medicare is making progress toward uniform national performance by carriers in checking physicians' charges, according to Thomas M. Tierney, director, Bureau of Health Insurance, Social Security Administration. (Mr. Tierney's comments were published in *Medical Economics*) "Physicians in all areas can be assured that they are being reimbursed neither more liberally nor more strictly than physicians in other localities," Tierney stated. In April, he reports, Medicare reduced more than 18% of all Medicare part B bills submitted.



# Your Area Needs More Doctors?

## Facts

1. The proposed increase in medical graduates won't even keep up with the increase in the population.
2. Federal promises of complete medical care for those over 65, the medically indigent and those on relief places demands impossible to satisfy on medical personnel and facilities.
3. The demand for physician services is greatly increased by our ability to extend the lives of those suffering with advanced heart disease, kidney disease, pulmonary disease and cancer.
4. Over 100 towns and villages in Illinois have no physician and no section of the state has enough doctors. *For the above reasons this shortage is destined to get worse.*
5. The percentage of medical graduates from schools in Illinois who stay in the state is lower than for any other state which has medical schools. More Illinois graduates go to California alone than stay in Illinois.
6. The average young man who enters medical school has compassion for his fellow man and is motivated to serve him. In the ivory tower atmosphere of the modern medical school, he is surrounded and instructed by those who are dedicated to excellence in research or in a narrow specialty. He comes to believe that quality medicine is only found in large teaching institutions.
7. He never learns that quality medicine is also practiced in most of the hospitals in this state. He learns nothing of the satis-

factions to be gained in serving individual persons who become his friends and who will accord him great respect and affection. He has no concept of the joys and comforts for him and his family when he lives and serves away from the metropolis.

## An Opportunity

Many of the students in Chicago's five medical schools still retain their desire to serve their very own patients and would welcome the opportunity to spend a weekend with an Illinois doctor. They would like to see his office, his hospital, his people and how he lives.

Invite one to visit you. If he is married, invite his wife also. It will be an enjoyable experience for you. Many of those who visit Illinois physicians will like what they see and eventually settle in Illinois. At least they will talk to other students about this experience. This is simply an introductory program; there is no obligation for the student to settle in your area, nor for you to accept him if he wishes to come.

Since most students are financially embarrassed, the invitation should include traveling expenses. Perhaps a group at your hospital could go together and invite one or more students sharing the expense and in hosting time. The experience will be rewarding for you and perhaps help to alleviate the doctor shortage in Illinois.

Write to:

Illinois State Medical Society  
360 North Michigan Avenue  
Chicago, Illinois 60601

Attention: Mr. Perry L. Smithers

## Looking for a Place to Practice? Placement Service Lists Openings

In an effort to reduce the number of towns in Illinois needing practicing physicians, the *Journal* is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

**ROCK ISLAND COUNTY:** Rock Island; population: 52,000. Trade area: 150,000. Attractive openings for GPs and specialists in all categories; 33 local doctors, 115 in 10 mile radius. St. Anthony's Hospital. Thirteen prescription stores. Rock Island and Burlington railroads. Quad City Airport. Downtown locations available if desired.

Sources of income: farm implements, R.I. Arsenal, and agriculture. Catholic, Protestant and Jewish churches. Excellent schools. Augustana College. Nine parks, eight golf courses, four riding academies, country clubs, boating, etc. For details contact: C. P. Cunningham, M.D. or C. P. O'Neill, M.D.

**SANGAMON COUNTY:** Divernon; population: 1,000. Town without physician for several years. Nearest physician 6 miles. Nearest hospitals, 17 miles at Springfield. New medical clinic building. Sources of income: agriculture and industry. Grade and high schools. Local country club; golf, swimming and dining facilities. Eighty-eight miles from St. Louis. For further information contact: Mrs. Wayne C. Bord, Superintendent of Schools, Box 135, Divernon. Phone: 628-3414.

**SCHUYLER COUNTY:** Rushville; population: 2,800. Trade area, 28,000. Two physicians in full time practice; 1 in limited practice; several retired recently. Culbertson Memorial Hospital, 56 beds. Within 60 miles of Peoria, Springfield and Quincy. Two prescription drug stores. Sources of income: agriculture and two meat packing plants. Protestant and Catholic churches. Organizations: Rotary, Masonic Lodge, IOOF, Moose, Chamber of Commerce, etc. Local park with swimming pool, golf course. Good fishing and hunting in area. Forty bed wing planned for hospital. For further information contact: Administrator, Culbertson Memorial Hospital, Rushville.

**SCOTT COUNTY:** Bluffs; population: 900. Trade area, 3,000. Nearest hospitals and physicians at Jacksonville and Beardstown, 20 miles. Town without a physician since Dec., 1968. Sixty miles from Springfield. Modern medical building available. Financial assistance available. Agricultural area. Five Protestant and Catholic churches. Grade and high schools. Excellent recrea-

tional facilities. New public library. Secure professional evaluation from Jacksonville physicians.

**SHELBY COUNTY:** Herrick; population: 650. Trade area, 3,000. Nearest physician 9 miles. One dentist. Nearest hospitals at Pana, Shelbyville, Effingham and Vandalia. Fifty-two miles from Decatur. No drug store. Free office space. Financial assistance if desired. Agricultural area. Five protestant churches. Grade and high schools. Excellent hunting and fishing in area. Nearest golf course at Pana. New Kaskaskia development project nearby. For further information contact: J. R. Carroll, Herrick.

**STARK COUNTY:** Toulon; population: 1,213. Only physician died in November, 1968. Nearest physician at Wyoming, 6 miles. Nearest hospitals at Kewanee, 14 miles. Forty miles from Peoria with 3 hospitals. Centrally located property has been purchased on which a medical center could be built. Agricultural community. Kraft factory located here. Churches: Baptist, Methodist, Congregational, Catholic and Christian Science. Grade and high schools. Nearest country clubs at LaFayette and Kewanee. For further information contact: Allen Williams, 129 West Main Street, Toulon, or J. Merlyn Kidd, Toulon.

**ST. CLAIR COUNTY:** Marissa; population: 2,000. One physician; second with large practice died recently. Nearest doctors, 12 miles; Sparta; local hospital. Thirty-eight miles from East St. Louis. Prescription drug store. Low office rent first year. Predominant nationality: German and Irish. Five churches. Grade and high schools. Golf and swimming facilities locally. Four physician friends of deceased physician keeping office open temporarily. Sufficient practice for 2 physicians. For further information contact: Robert G. Heil, 207 North Main, Marissa. Phone: 618-295-2351.

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### Counterattack on Campuses

"Parents with children in college should encourage them, representing the majority as they do, to democratically oppose and lawfully control the nihilistic, destructive, revolutionary student."—William C. Sullivan, assistant director, Federal Bureau of Investigation.

"The free enterprise system cannot continue to succeed if private business is not willing to play a role in shaping our environment as well as responding to it . . . Most important in long-range corporate planning is to put the urban problems on the organization chart."—G. William Miller, president, Textron, Inc.



# School Lunch Program

BY ROBERT K. CHERRY

As in all other areas of food service, the school feeding segment is faced with rising costs, shortage of skilled labor, less available space, and shifting population. These factors, as well as the public's desire for more food service to our school children are responsible for the shift to central preparation and satellite feeding. According to Dept. of Agriculture figures, 25% of the population is enrolled in schools. In 1968, 72% of the children or 36.8 million were enrolled in elementary school, 28% or 14.4 million were enrolled in secondary schools, and there were 1.7 million pre-schoolers. Twenty million children were served a "Type A" lunch daily, and yet 10 million children receive no food service at all. It is becoming less and less feasible to construct and/or maintain individual cafeterias in all schools in a district. New kitchens and cafeterias cost from \$15,000 to over \$60,000 for each facility not including building, interiors, grounds, or utilities.

## Program is Flexible

The Ekco Prepackaged Lunch Program in many aspects is unique. While there are optimum methods for the operation of this program, the essence of the program is its flexibility. Each school district using this

system is considered as a separate entity and the program modified to fit the particular set of circumstances.

While most school districts going into this type of lunch program will have experienced food service personnel available, the program requires changes in thinking and methods. Depending on the size of the district, the food service operation is changed to a food production plant. The introduction of a storage period after assembly may require different handling methods to maintain high quality standards. Chemical and biological processes which occur in foods must be understood and controlled more closely than in the usual restaurant or cafeteria situation.

With the proper work attitudes and knowledge of food production practices, this system will function very smoothly and economically. In conventional kitchens, the national average of meals per employee hour is 12 to 14. Using the bulk transport system, the average is 14-18, while with the Prepackaged Lunch Program, the average is over 20. Since all aspects of this program from raw material procurement to serving time can be controlled by the Food Service Director, many difficult problems faced by the industrial food manufacturer are eliminated.

The Prepackaged School Lunch System consists of five basic operations: Preparation, Packaging, Distribution, Heating,

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Robert K. Cherry (not pictured) is Technical Service Specialist, Ekco Products, Inc., Wheeling. He holds a B.S. degree in chemistry and biology from Roosevelt University. In addition, he is a member of the Institute of Food Technologists.

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*This paper was presented at the Symposium on Nutrition and Food Technology, Chicago, Feb. 12, 1969. This is the fifth in a series of five papers.*

and Serving. Lunches are prepared and packaged in a central kitchen, then shipped to "Satellite" schools, where they are heated and served to the students. This program utilizes the "Type A" lunch to its fullest potential, allowing the school district maximum subsidies and commodities under the School Lunch Act. Without going into too much detail, a "Type A" meal consists of  $\frac{1}{2}$  pint of whole milk, 2 oz. of lean meat or its equivalent,  $\frac{3}{4}$  cup of 2 or more vegetables, fruits, or combination of both, 1 slice of whole grain or enriched bread, and 2 teaspoons of butter or fortified margarine. The results satisfy students, teachers, administrators, parents, and the community by producing a hot, balanced meal for every student with minimum facilities. Centralized purchasing and inventory control also permit easier control of food costs.

Better utilization of equipment at the central kitchen means less equipment is required. Menu components to be served hot, such as meat portions, casserole items, stews and vegetables are prepared in advance in the central kitchen the afternoon prior to serving.

In many districts, the packaging of the hot portion is also done the afternoon prior to serving. Existing equipment can be utilized in food preparation for the Prepackaged School Feeding System, substantially reducing the cost of introducing this program. Over 25% of normal production, including items, such as: canned vegetables, canned entrees, frozen hamburgers, frozen fish sticks, and refrigerated hot dogs go directly from the vendor to the packaging line without requiring any additional preparation. There are two very large districts, both serving in excess of 6,000 meals per day, which use convenience foods of one type or another exclusively.

Cold items, such as gelatin desserts, puddings, cakes and cookies can also be prepared ahead of time. After preparation, all foods are moved to a refrigerated holding area until packaging is begun. At this time, the minimum amount of food needed to keep the packaging lines in constant operation is removed from the refrigerator at one time.

The next morning, the packaging line is prepared for packing the remainder of that day's meals. The satellite schools phone in the number of individual lunches they

will need for today, giving the number of faculty as well as children's meals. With the smaller districts, this works extremely well. The method of collecting lunch counts varies from one district to another and is another example of the flexibility of this program.

Depending on the number of satellite schools being served and the total number of lunches being delivered, the type of vehicle used can vary. To determine if refrigeration is needed in the trucks, the routes are planned according to traffic patterns, number of satellites per route, total number of meals to be delivered, and length of delivery schedule. The routes are timed and when finally set up, recording thermometers are used to insure that the meals are held in the proper refrigerated range.

The baskets are securely fastened for their ride to the satellites, and it's off to the schools. At the satellite school, the lunches can be stored in roll-in refrigerators. Economies can be effected here with the use of an insulated blanket and portable refrigerant instead of the refrigerator. Convection ovens, located at the satellites, heat the hot pack portion of the lunch in minutes. One-hundred-sixty lunches can be heated in 15 minutes.

Almost any place can be utilized for heating lunches. One school uses a former broom closet. Because this school has no lunch room, the meals are served in the hall and the children then return to their classroom to eat. For safety reasons, we did not want to leave the oven in the hall. Since this room was available, and we could properly vent the oven and easily keep the area sanitized, we found this to be the most advantageous area.

An alternate method is the use of insulated carriers. The hot packs are heated in the central kitchen prior to delivery. While the insulated carrier system is in use in a few school districts, it is limited to very small districts; the truck route must be short and delivery made close to serving time. The only step that remains is the serving. A mobile serving cart can be used, which is the same height as the convection ovens, for ease in removal from the oven and delivery to the serving line.

The serving method is also quite flexible. Some women prefer to hand the hot pack to each student. This is not necessary, and



in many schools the students pick up both packs and their milk without assistance. Since the lunches are already positioned, the serving line runs smoothly and quickly.

The children are given the cold pack, which contains all the utensils first, then the hot pack, and the milk. The serving sequence has two purposes: first, the children will be holding the cold portion of the lunch and will not burn their hands and secondly, the hot pack will cling to the film of the cold pack, making it almost impossible to spill or drop because of sliding.

An alternate serving method is feeding in the classroom using a room delivery cart, which is large enough to hold hot packs, cold packs, and milk on the shelf below. After heating, the complete meals can be transported to each room, thus eliminating over-crowded lunch rooms or the need of building lunch rooms, if they do not now exist. In the warmer climates, lunches are even served outdoors. Since everything is disposable, the children clear the tables; disposal of cartons, containers, and utensils are easily handled.

We believe this can be the answer to feeding today's school children—a HOT LUNCH PROGRAM, serving a variety of meals. We feel this program can overcome the problem facing school feeding today. The Prepackaged Lunch Program utilizes existing preparation facilities to the maximum. By centralized preparation, only one staff under one supervisor can serve a district.

New schools can have lunch programs without expensive outlays for space, preparation equipment, and staff. Shifting enrollments do not mean unused equipment in one school and overtaxed equipment in another. Day-to-day fluctuations in student participation in the lunch program do not result in wasted food. Schools previously unable to have a lunch program can now serve hot, nourishing lunches to their students and do it without expensive equipment and with fewer personnel.

True production methods must be used to realize the full economic advantage this system offers, and, at the same time, we must remember that we are not only producing nourishing meals, but tasty meals that the children will enjoy. ◀

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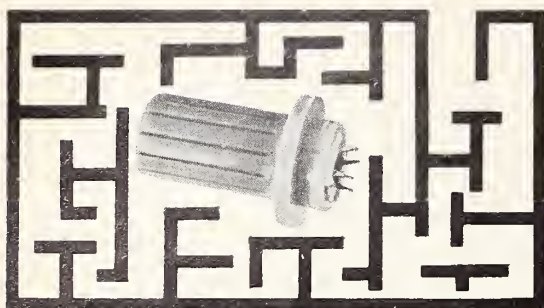
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## SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturer's package insert or brochure.

**Single Chemicals:** Drugs not previously known, including new salts.

**Duplicate Single Products:** Drugs marketed by more than one manufacturer.

**Combination Products:** Drugs consisting of two or more active ingredients.

**New Dosage Forms:** Of a previously introduced product.

### DUPLICATE PRODUCTS

**INFLAMASE** Eye preparation R

**Manufacturer:** Smith, Miller & Patch, Inc.

**Nonproprietary Name:** Prednisolone Sodium Phosphate

**Indications:** Inflammation of the eye (cornea, conjunctiva and eyelid), corneal injuries, and allergic reactions.

**Contraindications:** Acute herpes simplex, ocular tuberculosis, varicella and most other viral diseases of the cornea and conjunctiva; fungal diseases of the eye; most dendritic ulcers. Purulent conjunctivitis and blepharitis, and infectious conditions are general contraindications to steroid therapy.

**Dosage:** Initial: 1 or 2 drops in conjunctival sac q.1h. during day and q.2h. during night until improvement occurs.

**Maintenance:** 1 or 2 drops 2-4 times daily.

**Supplied:** Ophthalmic solution—0.125% and 1%, plastic dropper bottles of 5 cc.

**NEUT** Hospital Solution R

**Manufacturer:** Abbott Laboratories

**Nonproprietary Name:** Sodium Bicarbonate Solution.

**Indications:** To neutralize acidic parenteral solutions.

**Contraindications:** None mentioned.

**Dosage:** 20 cc. to a liter of parenteral solution.

**Supplied:** Abbo-Vials: 20 cc. of 1% sol.

**PROCTOCORT** Corticoid—Local R

**Manufacturer:** Rowell Laboratories

**Nonproprietary Name:** Hydrocortisone

**Indications:** Treatment of severe ano-rectal inflammation, pruritus or swelling; other inflammatory skin disorders responsive to corticosteroid therapy.

**Contraindications:** Tuberculosis of the skin, herpes simplex vaccinia, varicella. Fungal or bacterial skin infections unless treated concomitantly with appropriate antimicrobial therapy.

**Dosage:** Apply liberally to affected area 2-4 times daily.

**Supplied:** Cream—1%, tubes of 1 oz., with rectal applicator.

(Continued on page 306)



## — THE VIEW BOX —

(Continued from page 246)

**Diagnosis:** Carcinoma of the left upper lobe with complete atelectasis of the lobe.

In July, we demonstrated the roentgen signs of left lower lobe atelectasis. This month the emphasis will be on the radiographic diagnosis of left upper lobe atelectasis. The actual etiology is unimportant in this case. What is important is to recognize that atelectasis exists, which then limits the number of possibilities diagnostically.

The signs of left upper lobe atelectasis are as follows:

The PA view demonstrates a positive silhouette sign with the effacement of the left heart border, indicating that the lesion is located anteriorly. The left hilum overlay sign is also demonstrated. This radiographic finding states that the left pulmonary artery is normally clearly identified; however, should a mass lesion be present in the area, it will obscure this anatomical landmark. The left hilum itself is somewhat elevated. The radiolucency just to the left of the aortic knob represents hyperaeration of the right upper lobe extending across the mediastinum as a result of the left upper lobe collapse. The aortic knob is not well identified, and the explanation for this will be better understood when the lateral film is discussed. The secondary signs of tracheal shift and rib interspace narrowing are not

evident in this case.

The lateral view is extremely interesting and diagnostic. The concave anterior bowing of the major septum is well identified with radiolucent compensatory emphysema of the left lower lobe visualized. The clear area in front of the aorta represents the previously described compensatory emphysema of the right upper lobe, which has shifted across the mid-line anteriorly. The left upper lobe is now wedge-shaped and parallels the sternum down to the level of the diaphragm as a result of collapse of the lingula segment as well. It is now obvious that we will see the descending aorta outlined because the collapsed left upper lobe has shifted anteriorly away from it, and will not obscure it (negative silhouette sign). This is better demonstrated on a Bucky chest film. The aortic knob will be obscured in total collapse of the left upper lobe because of overlap caused by the overlying collapsed segment over the aorta on its anterior aspect (positive silhouette sign). Bronchoscopy revealed a neoplastic invasion with complete occlusion of the left upper lobe bronchus.

### Reference

FUNDAMENTALS OF CHEST ROENTGENOLOGY, B. Felson,  
W. B. Saunders, Philadelphia, Pa.

## New Law Enacted to Attract Physicians to Illinois

BY FRANK M. PFEIFER, ISMS LEGAL COUNSEL

The Illinois Legislature passed, and Governor Ogilvie signed into law, a bill which authorizes all counties other than Cook and all cities and villages in the State to provide medical service facilities which includes buildings for medical or dental offices, the necessary land for the building, and all furnishings and equipment needed for its operation, all of which may then be leased by doctors and dentists.

The counties and municipalities may provide for the acquisition, construction and equipping of such medical facilities which may then be leased to one or more physicians or dentists, and if approved by a vote of the people, may issue general obligation bonds for the cost. The governmental

unit issuing the bonds may then levy a tax to pay said bonds.

The governmental unit may lease the medical service facilities upon such terms as may be fixed and agreed upon, which terms may be revised from time to time with consideration being given both for the need for revenue to reduce the tax rate and to the overall purpose of establishing and providing proper medical care for the area. The rent paid need not necessarily be proportionate to the property rented. All property coming within the terms of this act is exempt from local taxation.

The legislative purpose in enacting this bill was an attempt to attract more physicians to Illinois. ◀

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## New Pharmaceutical Specialties

(Continued from page 304)

### COMBINATION PRODUCTS

**MICROSYN** Dermatologic Preparation—Resorcinol o-t-c

Manufacturer: Syntex Laboratories

Composition: Sodium thiosulfate 8%  
Salicylic acid 2%  
Resorcinol 2%  
Isopropyl alcohol 25%  
Menthol, camphor & colloidal alumina.

Indications: Treatment of acne.

Contraindications: None mentioned.

Dosage: Apply topically twice a day.

Supplied: Plastic squeeze bottles of 2 oz.

**PYOCIDIN-HC** Ear Preparations R

Manufacturer: Smith, Miller & Patch, Inc.

Composition: Each cc. contains:  
Hydrocortisone 10 mg.  
Polymyxin B sulfate 10,000 units  
Neomycin sulfate 5 mg.

Indications: External otitis, prevention of infection in dermatoses of the ear due to allergic neurogenic and seborrheic factors.

Contraindications: Tuberculosis, fungal or viral lesions of the skin, and hypersensitivity to any of the ingredients.

Dosage: 3-4 drops, 3 or 4 times daily.

Supplied: Solution—plastic squeeze bottles of 10 cc.

### NEW DOSAGE FORMS

**RONDEC T** Nasal Decongestant R

Manufacturer: Ross Laboratories

Composition: Carbinoxamine maleate 2.5 mg.  
Pseudoephedrine HCl 60.0 mg.

Indications: For histamine blocking mucosal decongestion and bronchodilation.

Contraindications: None mentioned.

Dosage: 1 tablet q.i.d.

Supplied: Tablets—bottles of 100.

**SYNOHYLATE-GG** Tablets Bronchial Dilator R

Manufacturer: The Central Pharmacal Co.

Composition: Theophylline sodium glycinate 300 mg.  
Glyceryl guaiacolate 100 mg.

Indications: Symptomatic treatment of bronchial asthma and other bronchospastic conditions.

Contraindications: Hypersensitivity to any of the ingredients.

Dosage: Adults: 1 to 2 tablets, q. 4-8h.

Children 6-12 yrs.: ½ to 1 tablet, q. 4-8h.

Supplied: Tablets, film coated—bottles of 100.

### "THOSE GOOD OLD GOLDEN RULE DAYS"

When I was a student, I was quiet;

I didn't protest, I didn't riot.

I wasn't unwashed, I wasn't obscene.

I made no demands on prexy or dean.

I sat in no sit-in, I heckled no speaker.

I broke not a window; few students were meeker.

I'm forced to omit with some hesitation,

All I got out of school was an education!



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**PRECAUTIONS:** Administer with caution to persons with known idiosyncrasy to atropine or cardiac disease. While under this therapy the urine is blue; patients should be so advised to allay apprehension.

**SIDE EFFECTS:** Neither irritation nor other untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occur, decrease dosage. If rapid pulse, dizziness, or blurring of vision occur, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

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## The President's Page

### Fee Moderation

(Continued from page 232)

Increased productivity does not necessarily imply more working hours, but the re-arrangement of the work day into the most efficient pattern. This may even mean adding facilities or personnel and thus increasing expenditures in order to increase income. Needless to say, we must never sacrifice the quality of patient care, and many physicians may find they are already working at their top level of productivity.

Doctor's fees are of course just a part of the total health cost picture although we are often blamed for all medical price increases. Soaring hospital charges take the biggest bite out of the patient's dollar. Yet the patient looks to the doctor as the captain of the health team to watchdog both his own fees as well as the hospital's.

This month I have tried to point out the importance of keeping physician's fees moderate. In the future, I will be suggesting ways we can also help curb hospital costs.

*Edward W. Connady*

Extensive research on sleep and dreaming—particularly the psychological aspects—is conducted in a sleep laboratory at the University of Illinois Medical Center Campus, Chicago. Research indicates there are two phases of sleep which reoccur in cycles: one is dreaming or the "active phase," and the second phase is called "deep sleep" which is characterized by little brain or eye activity.

\* \* \*

### EXERCISE CAN BE GOOD FOR HEART PATIENTS

An eight-year research project at the University of Illinois Medical Center Campus, Chicago, indicates that regular exercise can be good for some persons who have suffered heart attacks. Initial findings show that limited physical activity is not only good for the heart but if the exercise is done cautiously and regularly, the muscles of the heart can regain their lost strength.



## Water Related Tularemia

(Continued from page 277)

a source of human infection. Since both muskrats and man are known to have contracted tularemia from water,<sup>8</sup> it is reasonable to assume that migratory waterfowl would be exposed similarly. With the above in mind, it is not improbable that water may be involved in future tularemia outbreaks in man and the varied aquatic wildlife species that are subject to the disease. Practicing physicians should keep these epidemiological considerations in mind when a patient is presented to them with signs and symptoms compatible with tularemia. Further research should be initiated into two areas: 1. The susceptibility of geese and other aquatic wildlife to the tularemia organism; 2. The survival capabilities of the tularemia bacterium. ◀

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Epilepsy is as old as history itself. Yet, it remains one of the world's most misunderstood disorders. To get all the facts, write to Epilepsy Foundation of America, Washington, D.C., 20005.

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BASIC ELECTROCARDIOGRAPHY, One Week, October 6

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## Obituaries

\***Norris Brookens**, Urbana, died July 28 at the age of 57. He was a member of the Board of Education and a member of the Illinois Society of Internal Medicine. He was appointed by former Governor Kerner as Chairman of the newly created Board of Regents, Northern Illinois University and Illinois State University.

\***Margaret Cambier**, Peoria, died April 22 at the age of 62. She was on the staff of the Peoria State Hospital.

\***Michael Dmytrenko**, Aurora, died April 9 at the age of 50. He graduated from medical school in Russia.

\***Walter Libmann**, Quincy, died July 2 at the age of 56. He received his medical degree in Heidelberg, Germany.

**Norman Lindstedt**, Rockford, died April 16 at the age of 67.

**R. D. Martin**, Sullivan, died June 14 at the age of 76. He died in Osage Beach, Mo., where he retired.

\***Franck Metellus**, Chicago, died April 4 at the age of 60. He received his medical degree in Haiti.

\***Samuel Nelson**, Chicago, died April 6. He was past president of the Illinois chapter of the American Academy of General Practice. He was 66 years of age.

\***Orlin W. Rice**, Chicago, died July 20 at the age of 38. He was an attending physician at Holy Cross and Central Community hospitals.

\***James M. Severson, Sr.**, Rockford, died June 24 at the age of 78. He was past president of the Winnebago County Medical Society and a member of the ISMS Fifty-Year Club.

\***John R. Vonachen**, Peoria, died April 3 at the age of 77. He was past president of the Peoria County Medical Society and a member of the ISMS Fifty-Year Club.

\***Wenzel J. Wanninger**, Chicago, died in July at the age of 82. He was a past president of the South Chicago chapter of the Chicago Medical Society. He was a member of the ISMS Fifty-Year Club.

\*Indicates member of Illinois State Medical Society.

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Almost 70,000 motor vehicles were involved in fatal highway crashes in 1968. Of these, more than 55,200 were private passenger cars, according to The Travelers Insurance Companies annual statistics.



# BLUE SHIELD REPORT



## FOR *Illinois Physicians*

PUBLISHED MONTHLY BY: BLUE SHIELD PLAN OF ILLINOIS MEDICAL SERVICE • 222 NORTH DEARBORN ST. • CHICAGO, ILLINOIS 60601

Vol. 3, No. 10

October, 1969

### Prepayment In The U.S.

The forerunners of Blue Shield in the United States appeared at the turn of the century in isolated lumber and mining camps in the Pacific Northwest. Large companies contracted with individual doctors or groups of doctors to go into the camps and provide general medical services for workers on a monthly, prepaid basis.

Later, a number of county medical societies organized their own medical service bureaus and contracted with employers on behalf of the total members of the medical society, thereby enabling patients to retain their free choice of physician. Some county service bureaus are still operating, and several have merged into statewide Blue Shield Plans.

During the early 1930's, doctors concerned themselves more and more with ways by which their patients could pay for needed medical care.

In September, 1938, the House of Delegates of the American Medical Association, meeting in extraordinary session, endorsed for the first time the principle of voluntary health insurance.

This action was based on several factors: First, Blue Cross had already proved that hospital care could be prepaid and that the people, in large numbers, wanted to prepay it. Second, there was political pressures to include medical care in the new Social Security program. Finally, many physicians realized that a prepayment program was needed to assist people in obtaining modern medical care.

One of the earliest Blue Shield-type Plans was established in California in 1939 by the California Medical Association. During that same year Blue Shield Plans were established in Hawaii, Michigan, and Buffalo, N.Y.

The Blue Shield name and symbol were first used by the Buffalo Plan in 1939. Later, the Blue Shield designation and symbol became the exclusive right of Plans qualifying for, and holding, membership in the National Association of Blue Shield Plans.

It was Blue Shield—with its commitment from the medical profession—which developed a program whereby the individual could prepay his medical services. The concept was simple. Everyone in the program paid a small sum periodically to a central fund. When an individual in the program received services from a physician, the money in

### Blue Shield Usual and Customary Report

The Blue Shield Plan of Illinois Medical Service has just completed a two year analysis of its Usual and Customary program written for employees of the Steel Industry in August, 1967.

Over \$2½ million were paid by Blue Shield during this period for 28,000 professional services. This amount paid more than 97% of the total professional charges with 95% of the services paid in full.

The Blue Shield program for steel employees allows 100% payment of usual charges for physician's services within the customary range of usual charges. Other Blue Shield programs will pay 80% of usual charges for covered services and the "Blue Shield 65"—our Medicare complementary coverage allows 20% of usual charges within the customary range of usual charges.

Although more than half of our Blue Shield members still have protection based on fixed indemnity allowances, enrollment in our Usual and Customary program continues to grow.

### Reporting Services of Out-of-State Members

As of December 31, 1968, nearly 80 million persons were served by 77 Blue Shield Plans in the United States. Perhaps some of your patients were members of Plans located out of Illinois.

If so, you may report your services to out-of-state Blue Shield members by completing our regular *Blue Shield Physician's Service Report Form* and mailing it directly to the Blue Shield Plan listed on the identification card of your patient.

To assist you and your office personnel, a Directory of Blue Shield Plans, listing address, telephone number, and the executive officer of each Plan will be mailed to you upon request from the Professional Relations Department, Blue Shield Plan of Illinois Medical Service, 222 N. Dearborn Street, Chicago, Illinois 60601.

Each Plan provides allowances for its own members and in accordance with the type of protection the member has. Therefore, sending the report directly to the Plan involved will avoid undue delays.

the central fund would be used to pay the doctor.

This concept of medical-surgical "prepayment" caught on, and today Blue Shield is the nation's largest voluntary non-profit medical care prepayment organization.

(This is not an advertisement)

## ASK BLUE SHIELD

### • • • ABOUT MEDICARE

#### Clarification of Laboratory Services

Diagnostic X-Ray, laboratory and diagnostic tests such as basal metabolism readings, electrocardiograms, respiratory function tests, cardiac evaluations, allergy tests, electroencephalograms, psychological tests and otologic evaluations and the charge for materials and the services of the technicians are covered under the Medicare Program.

These tests are covered but only when they are furnished by the attending physician in connection with a definite diagnosis or set of symptoms, but not to rule out a cause, disease or condition.

The interpretation by a physician of an actual electroencephalogram reading is also covered if it has been transmitted by electronic telecommunication rather than verbally.

Diagnostic laboratory services such as microbiological, serological, chemical, hematological, biophysical, cytological, immunohematological, or pathological examinations are covered in an approved independent clinical laboratory.

A laboratory is considered "approved" by the Secretary of Health, Education, and Welfare when it is licensed or approved by the State and also meets the safety and health requirements prescribed by the Secretary of Health, Education, and Welfare.

The Regional Social Security Administration office provides Part B Medicare carriers with a listing of the approved laboratories located in their service area.

#### Assigned Claims

The 1967 Amendment to Social Security which allows a payment to be made on an itemized rather than a receipted bill is intended to provide the Medicare patient with the resources to help pay his physician's charges. But, it also increases the possibility of duplicate payment being made for the same service. It is possible, for example, for a physician to accept an assignment at the same time his patient submits an itemized bill for payment.

A physician who accepts an assignment will not be paid when the benefit has already been paid to his patient. Likewise, no payment will be made to his patient when the benefit has been paid to the physician.

When a Medicare patient's claim is received first, payment will be made to him. When a claim from a physician who accepts an assignment is received before payment is made to his patient, payment will be made to the physician provided the Medicare beneficiary has also agreed to the assignment by signing the "Request for Payment" Form, 1490.

Physicians who do accept assignments should submit claims promptly for services they have provided. And to reduce the possibility of duplicate claims being filed or duplicate payments being made, they should clearly indicate on their patients' bills that they accept assignment.

A physician who does not accept an assignment and submits an itemized bill to his Medicare patient, should include on each bill the patient's name; his name; the date, place, description of EACH service provided and the charge for EACH service. Unusual circumstances or complications should be described if they are reflected in the charge. This information is needed before payment can be made to Medicare patients for covered services.

#### Complete Information Needed

In order to speed Medicare payments, it is necessary to include detailed information on the Medicare "Request for Payment" Form 1490 or on an itemized statement attached to an SSA 1490 Form. When information is omitted, Medicare regulations require the carrier to obtain the necessary information. In Cook, Kane, Will, Lake and DuPage counties several hundred letters are mailed daily by Illinois Blue Shield to obtain additional information before the Medicare claim can be processed and paid.

The majority of these letters are mailed to obtain the following information:

- (1) Itemization of charges—  
Example: If during an office visit a C.B.C. is done, the Social Security Administration requires the charge indicated for the office visit and the C.B.C.;
- (2) Diagnosis;
- (3) Date each service was provided;
- (4) Length of time anesthesia was administered;
- (5) Extent, size and location of a lesion;
- (6) Location of a fracture and whether or not it was open or closed reduction;
- (7) Name of the drug used for an injection and the charge;
- (8) Itemization of laboratory charges;

By including this information on your Medicare claim or itemized statements, you will help us to speed payments to you or to your patient.





Edward W. Cannady, M.D.

# The President's Page

Whenever physicians are criticized for fee increases, we are often tempted to respond: "If you think doctors' fees are high, just look at what the hospitals are charging."

Fortunately, such sentiments are seldom verbalized, since they imply that hospitals are somehow the bandits behind spiraling health costs, and that doctors are merely innocent bystanders.

The problem of hospital costs is not just a hospital problem. It is our problem as well, and any physician who feels that his responsibility for moderating medical costs stops outside his office door is gravely mistaken.

As physicians, we hold two unique and important functions in hospital operations, each having a direct relationship to hospital costs and charges to patients.

Our first function is that of peer review through our hospital Utilization Review Committees. It is generally agreed that hospital costs will continue to burgeon as long as hospital salaries remain below industrial standards. Thus, it is absolutely essential that we use our hospital manpower and expensive facilities to their full potential.

This means maximizing the use of every hospital bed, insuring that every patient is there—not because his insurance pays for it or because he doesn't want to go home—but because he is genuinely benefiting from hospital services.

Abuse of hospital services was spotlighted recently in the furor over the cost of the Medicare program, but the government is not alone in its concern. The private insurance companies and Blue Cross plans are clamoring for more effective examinations of hospital utilization.

The Utilization Review Committee can be a highly effective instrument of examination and, if used properly, I believe it can have a significant impact on hospital costs in the long run. If used improperly, or not at all, the UR committee can be

embarrassing testimony to the too-frequent charge that doctors are interested in themselves first, and their patients second.

I know of many strong UR committees that provide their hospitals and the hospital patients with an invaluable service. The members of these committees are to be commended. To judge one's peers is no easy task, but it is necessary. Whether we are the one who reviews, or the one being reviewed, peer examination is a constant reminder that we cannot afford the luxury of misusing hospital services.

Our second role in relationship to hospital costs is our function as the patient's purchasing agent. I will not belabor this issue, since I feel most doctors exercise prudent judgment in ordering hospital services for their patients. At times, however, we do have a tendency to forget that every decision we make regarding hospital care usually carries a price tag. That price tag may seem small to us, but it may be very large to the patient.

In the first six months of this year, hospital daily service charge climbed six per cent. Daily service charges are now 150 per cent higher than they were in 1958. If you haven't checked into what hospitals in your area are charging lately, you might do so. You may be surprised.

You might also consider becoming a board member in your local hospital, although I realize there are a good number of hospital boards which do not have physician representation. For the past several years ISMS has urged that doctors be included on hospital boards, and we feel that several hospitals have opened their boards to doctors as a result.

Participation on hospital boards will not only provide you with insights into the difficult problem of hospital costs, it will also give you a chance to offer constructive solutions.

*Edward W. Cannady*

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*References:* 1. Danhof, I. E.: Report on file. 2. Hoon, J. R.: Arch. Surg. 93:467 (Sept.) 1966.

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Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

**Side Effects** include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis,

# ubadubdub lubad

Anxiety is expected in the cardiovascular patient. A little may even be desirable.

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And perhaps prescribe Equanil (meprobamate) as adjunctive therapy. It helps relieve anxiety and tension specifically, yet gently.

Almost 15 years' use has shown that Equanil is usually well tolerated as well as effective. Side effects are generally limited to transient drowsiness; serious, therapy-interrupting side effects are rare.

stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration. Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

**Composition:** Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

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## ON THE COVER

### This is your Annual Reference Issue!

As has been done for five previous years, the October issue of your **Illinois Medical Journal** is devoted to a recording and reporting of the many and varied aspects of health related activities in Illinois. Quickly leafing through the pages you will immediately ascertain that a substantial amount of basic information can be gleaned.

Since this is an extremely important issue of the **IMJ**, it is urged that you retain this issue near at hand for easy reference.

You will note various sections devoted to the history of ISMS, the constitution and bylaws, policies, councils and committees, and various ISMS services. In addition there are listings of the many services through the state of Illinois departments. Listings of facilities and institutions make reference to a location easier.

Due to the many new acts of the 1969 legislature, the Medical-Legal section has had to be delayed. Although signed into

law in late September, press deadlines obviated a full treatise on the ramifications of the acts. Among these were the new Good Samaritan Act, the Uniform Anatomical Gift Act, Minor Consent for Treatment, Medical Corporations, and so on. These will be covered in a future issue of the **IMJ**.

The cover this month depicts the thought that there is a definite intersticing between all the facets of professional medicine, public health, education, public affairs, and government. Not only is there such interplay, but the direction is outward rather than inward to reach into every area of endeavor and concern.

Through this rendering one gains the impression that medicine today is actively engaged in bettering the lot of all citizens, that it is a vigorous force in today's society, and that it is effectively meeting the challenges offered.

---

### **Optimal Conditions for Civilized Life**

The maintenance of law and order, a satisfactory economic system, international co-operation, and the prevention of war, are all necessary, if the highest average national and international standards of physical health are to be achieved. The full development of human personality in a modern Utopia is less certain. Ordinary experience of life, and the pages of history, reveal only too clearly that, while minds cannot develop to the full under satisfactory conditions, a certain amount of stress, strain, and risk is necessary for the maximum development of human character. Unless human nature changes, however, perfect environmental conditions, even if they can ever be achieved, are not likely to persist. Nevertheless, we can work for improvement in moral and intellectual standards, on which the maintenance of satisfactory conditions of life ultimately depends, and in the meantime more could be done to maintain a higher average level. But while, on the one hand, conditions of life in the environment may be much too bad and the risks in the environment far too great, we know that under certain circumstances life can be too comfortable to promote health, and too soft for the development of personality. Moreover, the elimination of all risk would seriously curtail individual liberty and freedom.—A. E. Clark-Kennedy, M.D., F.R.C.P.: **The Art of Medicine in Relation to the Progress of Thought**, Cambridge University Press, London, 1945, pp. 27-28.



## ISMS ORGANIZATION

### History of Founding and Expansion

TWENTY-NINE PHYSICIANS met in Springfield June 4, 1850, to organize on a permanent basis the Illinois State Medical Society, which had been started informally 10 years earlier. The founders were concerned with the solution of ethical, scientific, legislative and economic problems. The first Constitution and Bylaws and the first Code of Medical Ethics were adopted; the first legislative committee was appointed, and a resolution outlining the beginnings of interprofessional relations was approved.

The Legislative Committee was instructed to "memorialize the legislature at its next session, praying the enactment of a statute providing for the registration of Births, Deaths and Marriages." The resolution ruled that "members of the Society will discourage the sale of patent or secret nostrums on the part of Druggists and Apothecaries throughout the State, and will patronize insofar as practicable, only those who abstain from the sale of such patent or secret nostrums."

The first full time secretary of the Society was Dr. Harold M. Camp who served for over 35 years until his death in 1958. The first executive administrator, Robert L. Richards, was employed at the time the office was moved to Chicago in 1960 and served until February, 1966. After an interim service by Dr. George F. Lull, Mr. Roger N. White was selected as Executive Administrator in May, 1968.

The Society published the early transactions in

book form presenting not only the minutes of the House of Delegates, but also all scientific papers given at each annual convention. In 1898 a new era of communications began, for at that time, the *Illinois Medical Journal* was established and became the first "official organ of the Society."

Dr. G. N. Kreider was its first editor and served until 1913, followed by Dr. Clyde D. Pence with Dr. Henry G. Olds as the first managing editor. Dr. Charles G. Whalen became editor in 1919 and he and Dr. Olds served until they died in 1940. Dr. Camp followed Dr. Whalen and Dr. Theodore R. Van Dellen is the editor today.

Dr. Whalen spearheaded many important activities in medicine, and has been called "the outstanding champion of the medical profession in its economic contacts." He has been credited as one of the first medical editors to blast "the socialization of medicine in this country." In 1922 he wrote extensively on state medicine, workmen's compensation, compulsory health insurance, free hospitalization and federal aid.

The first Fifty Year Club in the United States was announced by the *Illinois Medical Journal* in 1938.

The fourth largest medical society in the country has developed from these embryonic beginnings. This edition of the *Illinois Medical Journal* offers you an opportunity to contrast the extensive services available to the membership today with those offered in the past.

# OFFICERS AND PLACES OF MEETING

YEAR	PRESIDENT	SECRETARY	TREASURER	MEETING PLACE
1840	John Todd	David Prince		Springfield
1850	Rudolph Rouse	Edwin G. Meek		Springfield
1850	William B. Herrick	Edwin G. Meek	Jno. Halderman	Springfield
1851	Samuel Thompson	H. Shoemaker	R. Rouse	Peoria
1852	Rudolph Rouse	E. S. Cooper	Edw. Dickenson	Jacksonville
1853	Daniel Brainerd	H. A. Johnson	A. B. Chambers	Chicago
1854	C. N. Andrews	H. A. Johnson	N. S. Davis	LaSalle
1855	N. S. Davis	E. Andrews	J. V. Z. Blaney	Bloomington
1856	H. Noble	N. S. Davis	J. V. Z. Blaney	Vandalia
1857	C. Goodbreak	H. A. Johnson	J. V. Z. Blaney	Chicago
1858	H. A. Johnson	N. S. Davis	J. W. Freer	Rockford
1859	David Prince	N. S. Davis	J. W. Freer	Decatur
1860	Wm. M. Chambers	N. S. Davis	J. W. Freer	Paris
1863	A. McFarland	N. S. Davis	J. H. Hollister	Jacksonville
1864	A. H. Luce	N. S. Davis	J. H. Hollister	Chicago
1865	J. M. Steele	N. S. Davis	J. H. Hollister	Bloomington
1866	F. F. Haller	N. S. Davis	J. H. Hollister	Decatur
1867	H. Noble	N. S. Davis	J. H. Hollister	Springfield
1868	S. T. Trowbridge	N. S. Davis	J. H. Hollister	Quincy
1869	S. T. Trowbridge	T. D. Fitch	J. H. Hollister	Chicago
1870	J. V. Z. Blaney	T. D. Fitch	J. H. Hollister	Dixon
1871	G. W. Albin	T. D. Fitch	J. H. Hollister	Peoria
1872	J. O. Hamilton	T. D. Fitch	J. H. Hollister	Rock Island
1873	D. W. Young	T. D. Fitch	J. H. Hollister	Bloomington
1874	T. F. Worrell	T. D. Fitch	J. H. Hollister	Chicago
1875	J. H. Hollister	T. D. Fitch	Wm. E. Quine	Jacksonville
1876	T. D. Washburn	N. S. Davis	J. H. Hollister	Urbana
1877	T. D. Fitch	N. S. Davis	J. H. Hollister	Chicago
1878	J. L. White	N. S. Davis	J. H. Hollister	Springfield
1879	E. P. Cook	N. S. Davis	J. H. Hollister	Lincoln
1880	Ephraim Ingalls	N. S. Davis	J. H. Hollister	Belleville
1881	G. W. Jones	S. J. Jones	J. H. Hollister	Chicago
1882	Robert Boal	S. J. Jones	J. H. Hollister	Quincy
1883	A. T. Darrah	S. J. Jones	J. H. Hollister	Peoria
1884	E. Andrews	S. J. Jones	Walter Hay	Chicago
1885	D. S. Booth	S. J. Jones	Walter Hay	Springfield
1886	Wm. A. Byrd	S. J. Jones	Walter Hay	Bloomington
1887	Wm. T. Kirk	D. W. Graham	Walter Hay	Chicago
1888	Wm. O. Ensign	D. W. Graham	Walter Hay	Rock Island
1889	C. W. Earle	D. W. Graham	T. W. McIlvaine	Jacksonville
1890	John Wright	D. W. Graham	T. W. McIlvaine	Chicago
1891	Jno. P. Mathews	D. W. Graham	Geo. N. Kreider	Springfield
1892	Charles C. Hunt	D. W. Graham	Geo. N. Kreider	Vandalia
1893	E. Fletcher Ingals	D. W. Graham	Geo. N. Kreider	Chicago
1894	Otho B. Will	J. B. Hamilton	Geo. N. Kreider	Decatur
1895	Daniel R. Brower	J. B. Hamilton	Geo. N. Kreider	Springfield
1896	D. W. Graham	J. B. Hamilton	Geo. N. Kreider	Ottawa
1897	A. C. Corr	J. B. Hamilton	Geo. N. Kreider	East St. Louis
1898	J. N. G. Carter	E. W. Weis	Geo. N. Kreider	Galesburg
1899	J. T. Pitner	E. W. Weis	Geo. N. Kreider	Cairo
1900	H. N. Moyer	E. W. Weis	Geo. N. Kreider	Springfield
1901	G. N. Kreider	E. W. Weis	E. J. Brown	Peoria
1902	J. T. McAnally	E. W. Weis	E. J. Brown	Quincy
1903	M. L. Harris	E. W. Weis	E. J. Brown	Chicago
1904	C. E. Black	E. W. Weis	E. J. Brown	Bloomington
1905	W. E. Quine	E. W. Weis	E. J. Brown	Rock Island
1906	H. C. Mitchell	E. W. Weis	E. J. Brown	Springfield
1907	J. F. Percy	E. W. Weis	E. J. Brown	Rockford
1908	W. L. Baum	E. W. Weis	E. J. Brown	Peoria
1909	J. W. Pettit	E. W. Weis	E. J. Brown	Quincy
1910	J. L. Wiggins	E. W. Weis	E. J. Brown	Danville
1911	A. C. Cotton	E. W. Weis	E. J. Brown	Aurora



YEAR	PRESIDENT	SECRETARY	TREASURER	MEETING PLACE
1912	W. K. Newcomb	E. W. Weis	E. J. Brown	Springfield
1913	L. H. A. Nickerson	E. W. Weis	A. J. Markley	Peoria
1914	Charles J. Whalen	W. H. Gilmore	A. J. Markley	Decatur
1915	A. L. Brittin	W. H. Gilmore	A. J. Markley	Springfield
1916	C. W. Lillie	W. H. Gilmore	A. J. Markley	Champaign
1917	W. L. Noble	W. H. Gilmore	A. J. Markley	Bloomington
1918	E. B. Coolley	W. H. Gilmore	A. J. Markley	Springfield
1919	E. W. Fiegenbaum	W. H. Gilmore	A. J. Markley	Peoria
1920	J. W. Van Derslice	W. H. Gilmore	A. J. Markley	Rockford
1921	W. F. Grinstead	W. H. Gilmore	A. J. Markley	Springfield
1922	Charles Humiston	W. H. Gilmore	A. J. Markley	Chicago
1923	E. P. Sloan	W. D. Chapman	A. J. Markley	Decatur
1924	E. H. Ochsner	W. D. Chapman	A. J. Markley	Springfield
1925	L. C. Taylor	H. M. Camp	A. J. Markley	Quincy
1926	J. C. Krafft	H. M. Camp	A. J. Markley	Champaign
1927	Mather Pfeifferberger	H. M. Camp	A. J. Markley	Moline
1928	G. Henry Mundt	H. M. Camp	A. J. Markley	Chicago
1929	J. E. Tuite	H. M. Camp	A. J. Markley	Peoria
1930	F. O. Fredrickson	H. M. Camp	A. J. Markley	Joliet
1931	Wm. D. Chapman	H. M. Camp	A. J. Markley	East St. Louis
1932	R. R. Ferguson	H. M. Camp	A. J. Markley	Springfield
1933	John R. Neal	H. M. Camp	A. J. Markley	Peoria
1934	Philip H. Kreuscher	H. M. Camp	A. J. Markley	Springfield
1935	Charles D. Center*			
(Past President-Elect)				
1935	Charles S. Skaggs	H. M. Camp	A. J. Markley	Rockford
1936	Chas. B. Reed	H. M. Camp	A. J. Markley	Springfield
1937	Rolland L. Green	H. M. Camp	A. J. Markley	Peoria
1938	R. K. Packard	H. M. Camp	A. J. Markley	Springfield
1939	S. E. Munson	H. M. Camp	A. J. Markley	Rockford
1940	Jas. H. Hutton	H. M. Camp	A. J. Markley	Peoria
1941	J. S. Templeton	H. M. Camp	A. J. Markley	Chicago
1942	Chas. H. Phifer	H. M. Camp	H. M. Camp	Springfield
1943	E. H. Weld	H. M. Camp	H. M. Camp	Chicago
1944	G. W. Post**	H. M. Camp	H. M. Camp	Chicago
1945	E. P. Coleman	H. M. Camp	H. M. Camp	***
1946	E. P. Coleman	H. M. Camp	H. M. Camp	Chicago
1947	R. S. Berghoff	H. M. Camp	H. M. Camp	Chicago
1948	I. H. Neece	H. M. Camp	H. M. Camp	Chicago
1949	Percy E. Hopkins	H. M. Camp	H. M. Camp	Chicago
1950	Walter Stevenson	H. M. Camp	H. M. Camp	Springfield
1951	Harry M. Hedge	H. M. Camp	H. M. Camp	Chicago
1952	C. Paul White	H. M. Camp	H. M. Camp	Chicago
1953	Leo P. A. Sweeney	H. M. Camp	H. M. Camp	Chicago
1954	Willis I. Lewis	H. M. Camp	H. M. Camp	Chicago
1955	Arnell M. Vaughn	H. M. Camp	H. M. Camp	Chicago
1956	F. Garm Norbury	H. M. Camp	H. M. Camp	Chicago
1957	F. Lee Stone	H. M. Camp	H. M. Camp	Chicago
1958	Lester S. Reavley	H. M. Camp	H. M. Camp	Chicago
1959	Raleigh C. Oldfield	H. M. Camp	H. M. Camp	Chicago
1960	Joseph T. O'Neill	George F. Lull	George F. Lull	Chicago
1961	H. Close Hesseltnie	Jacob E. Reisch	Jacob E. Reisch	Chicago
1962	Edwin S. Hamilton	Jacob E. Reisch	Jacob E. Reisch	Chicago
1963	George F. Lull	Jacob E. Reisch	Jacob E. Reisch	Chicago
1964	Harlan English	Jacob E. Reisch	Jacob E. Reisch	Chicago
1965	Edward A. Piszczek	Jacob E. Reisch	Jacob E. Reisch	Chicago
1966	Burtis E. Montgomery	Jacob E. Reisch	Jacob E. Reisch	Chicago
1967	Caesar Portes	Jacob E. Reisch	Jacob E. Reisch	Chicago
1968	Newton DuPuy	Jacob E. Reisch	Jacob E. Reisch	Chicago
1969	Philip G. Thomsen	Jacob E. Reisch	Jacob E. Reisch	Chicago
1970	Edward W. Cannady	Jacob E. Reisch	Jacob E. Reisch	Chicago

\*Died before induction into office

\*\*Died in office. Term completed by Robert S. Berghoff, First Vice President

\*\*\*Meeting cancelled 1945

# Principles Of Medical Ethics

**PREAMBLE:** These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

**SECTION 1—**The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

**SECTION 2—**Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

**SECTION 3—**A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

**SECTION 4—**The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

**SECTION 5—**A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving

adequate notice. He should not solicit patients.

**SECTION 6—**A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

**SECTION 7—**In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

**SECTION 8—**A physician should seek consultation upon request, in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

**SECTION 9—**A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

**SECTION 10—**The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.



# Constitution And Bylaws

## May 1969

Adopted, 1903  
As Amended, 1969

### CONSTITUTION

#### ARTICLE I. NAME

The name and title of this organization shall be the Illinois State Medical Society.

#### ARTICLE II. PURPOSES OF THE SOCIETY

The purposes of this Society are to promote the science and art of medicine, to protect the public health, to elevate the standards of medical education and to unite the medical profession behind these purposes; to promote similar interests in the component societies and to unite with similar organizations in other states and territories of the United States to form the American Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

#### ARTICLE III. COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Society.

#### ARTICLE IV. COMPOSITION OF THE SOCIETY

The Society shall consist of active members and such other members as the Bylaws may provide.

#### ARTICLE V. HOUSE OF DELEGATES

Section 1. The House of Delegates shall be the legislative body of the Illinois State Medical Society, and unless otherwise herein provided, its deliberations shall be binding upon the officers, including the Board of Trustees. The House of Delegates shall set the basic policy and philosophy of the Society.

Section 2. The House of Delegates shall elect the general officers, except as otherwise provided in the Bylaws.

#### ARTICLE VI. BOARD OF TRUSTEES

The Board of Trustees, whose duties are executive and judicial, shall have charge of all property and all financial affairs of the Society, and shall perform such other duties as are prescribed by law governing the directors of corporations, or as may be prescribed in the Bylaws.

#### ARTICLE VII. CONVENTIONS AND MEETINGS

The Society shall hold an annual convention during which there shall be a business meeting of the House of Delegates and general scientific meetings which shall be open to all registered members.

#### ARTICLE VIII. OFFICERS

The officers of this Society shall be a president, a president-elect, a first vice president, a second vice president, a secretary-treasurer, a speaker and vice speaker of the House of Delegates, sixteen trustees and one trustee at large, and such other officers as the Bylaws may provide.

#### ARTICLE IX. THE SEAL

This Society shall have a common seal with power to break, change or renew the same when necessary.

#### ARTICLE X. AMENDMENTS

The House of Delegates may amend this Constitution at any annual business meeting of the House of Delegates provided that the amendment shall have been proposed at the preceding annual business meeting, and that two-thirds of the members of the House of Delegates seated concur in the amendment.

### BYLAWS

#### CHAPTER I. MEMBERSHIP

##### Section 1. *Members.*

A. *Active Members.* The active members of this Society shall consist of regular members, emeritus members, retired members, provisional members, intern members and residency members. Active members shall enjoy full privileges which include membership in the American Medical Association.

B. *Special Members.* The special members of this Society shall be distinguished because of their contributions to the science and art of medicine.

(1) *Distinguished Members.* Distinguished members shall be:

a. Physicians of Illinois or other states, or foreign countries who have risen to prominence in the profession; or

- b. Teachers of medicine or of the sciences allied to medicine, not eligible for active membership; or
- c. Members of associated arts or sciences who have made significant contributions to medicine.

(2) *Election.* Special members may be nominated by any member of the House of Delegates, and may be elected by the House at any annual convention by a two-thirds vote.

(3) *Privileges.* Special members shall not be entitled to hold office nor to vote, and shall not be considered as members in determining the number of delegates to the American Medical Association, but they may participate in all other Society activities.

#### Section 2. *Qualifications for Membership.*

A. Every physician duly licensed and registered in the State of Illinois to practice medicine in all its branches who is a graduate of a medical school approved in the United States or Canada, a resident of the State of Illinois, a citizen of the United States, who is of good moral character and professional standing, and a member of his component medical society, shall be eligible for regular membership.

B. Provisional membership shall be available to any Illinois physician who has made a declaration of intention to become a citizen of the United States, who has received a license in this State to practice medicine in all of its branches, and who—with the exception of United States citizenship—possesses all of the qualifications for membership prescribed by these Bylaws. Provisional membership shall terminate one year after the expiration of the minimum period of time within which such member could have perfected his citizenship. After obtaining full citizenship and prior to the expiration of his provisional membership, such member may be, upon application to his component medical society, transferred to regular membership.

C. The following shall also be eligible if approved and recommended by the component medical society:

- (1) Every physician serving as a full time employee at the headquarters of the American Medical Association;
- (2) Physicians serving as medical officers in the United States Governmental Services, who are members of a component society, so long as they are engaged actively in their respective service, and thereafter, if they have been retired on account of age or physical disability, or after long and honorable

service under the provision of an Act of Congress;

D. Physicians otherwise eligible for membership, and licensed in one of the States of the Union, but not licensed in Illinois, and who are not engaged in the active practice of medicine, but otherwise employed in an allied medical activity which does not require licensure, shall be eligible for membership if approved and recommended by the component medical society and approved by the Board of Trustees.

Section 3. *Emeritus Members.* A member to be elected to emeritus membership shall:

- (1) currently be in good standing,
- (2) have been a member in good standing for 35 years,
- (3) have reached, or will have reached before the next fiscal year, the age of 70 years, and
- (4) have made written application to and have been recommended by his component society for emeritus status.

Such membership shall become effective January 1 of the year following election. Emeritus members shall have all the rights and privileges of membership without the payment of dues to the component or state society.

Credit for membership in other American Medical Association constituent societies shall be accorded transferees, provided they have been members of this Society for at least five years.

Section 4. *Retired Members.* A member who has been in good standing but who by reason of age or incapacity, has retired from active practice, may upon application to and upon recommendation of his component society, be made a retired member, without payment of dues to the component or state society.

Section 5. *Intern Members.* Any person who is a graduate of a medical school approved in the United States or Canada, who is of good moral character and professional standing and who is serving an internship in any hospital in the State of Illinois approved by the American Medical Association, is eligible for intern membership upon the recommendation of any two members of this Society who are also members of his hospital staff.

The physician's intern membership shall cease at the end of the year in which his internship training terminates, and if he wishes to become a member of this Society, he must apply for a residency or regular membership through his component society.

Dues for intern membership shall be minimal.

Section 6. *Residency Members.* After being licensed to practice medicine, a physician serving full time as a resident in a residency approved by the American Medical Association, is eligible for full membership.



Dues for residency members shall be minimal.

A residency member must be a graduate of a medical school approved in the United States or Canada, have a degree of Doctor of Medicine or its equivalent, and must be a member in good standing of his component society.

The physician's residency membership shall cease at the end of the year in which his residency training terminates, and if he wishes to become a member of this Society, he must apply for regular membership through his component society.

**Section 7. *Tenure of Membership.*** The name of a physician on the properly certified roster of members of a component society which has paid its annual assessments, shall be prima facie evidence of membership in this Society, and afford all the rights and privileges pertaining thereto.

**Section 8. *Withdrawal of Privileges.*** No person who is under sentence of suspension or expulsion from a component society, shall be entitled to any of the rights or benefits of this Society, nor shall he be permitted to take part in any of the proceedings until he has been reinstated.

**Section 9. *Student Committee Membership.*** Students nominated by Illinois Chapters of the Student American Medical Association, or other recognized student organizations approved by the Illinois State Medical Society Board of Trustees, to serve with Illinois State Medical Society members on appropriate committees, may by action of the Board of Trustees, be accorded membership in this classification for the term of the committee appointment. Such members shall be permitted full privileges of committee membership, including (with permission of the House of Delegates) the right to speak on the floor of the House, but shall have no vote out of committee. They shall pay no dues.

## CHAPTER II. ANNUAL CONVENTIONS

**Section 1. *Date.*** The Board of Trustees shall determine the date for the annual convention.

**Section 2. *Meeting Place.*** The meeting place for the annual convention shall be determined by the House of Delegates from a list of cities extending invitations, subject to investigation of the facilities and approval by the Board of Trustees.

**Section 3. *Scientific Meetings.***

A. With the consent of the House of Delegates or the Board of Trustees any special group may conduct its meeting in connection with the annual convention of this Society.

B. For the transaction of scientific business, there shall be one or more sections as may be determined from year to year by the Board of Trustees.

C. Section officers shall be appointed by the president of the Society from nominees recommended by the section, or if there are no

nominees, from a list submitted by the chairman of the Committee on Scientific Assembly.

D. The Scientific Program shall be conceived by the Committee on Scientific Assembly and developed and implemented through the joint efforts of the Committee on Scientific Assembly and representatives of specialty groups.

E. All registered members may attend and participate in the proceedings and discussions of the general scientific meetings and of the section meetings.

F. The general scientific meetings may recommend to the House of Delegates the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and to the public.

G. All papers read before the Society or any section thereof, shall become the property of the Society. Each paper shall be deposited with the secretary when read, and presentation of a paper to the Illinois State Medical Society shall be considered tantamount to the assurance on the part of the writer that such paper has not already been published.

H. The Board of Trustees shall be entirely responsible for the annual convention.

## CHAPTER III. THE HOUSE OF DELEGATES

**Section 1. *Composition.*** The voting membership of the House of Delegates shall consist of:

(1) Delegates elected by the component societies

(2) The president

(3) The president-elect

(4) The secretary-treasurer

(5) The speaker of the House (or the vice speaker when presiding) and

(6) The trustees.

Non-voting members shall be the vice presidents, the vice speaker (when not presiding), the past trustees, past speakers, past presidents, general officers of the AMA and delegates from the Illinois State Medical Society to the AMA.

**Section 2. *Meetings.*** The House of Delegates shall meet at the time and place of the annual convention of the Society, and shall fix its hours of meeting so that they shall not conflict with the general scientific meetings of the Society. If the interests of the Society and the profession require, the House of Delegates may meet in advance of the general scientific meetings.

**Section 3. *Quorum.*** Fifty delegates representing not less than twenty component societies shall constitute a quorum for the transaction of business.

**Section 4. *Special Meetings.*** Special meetings of the House of Delegates may be called by the president or a majority of the Board of Trustees, or shall be called on petition of twenty component societies.

When a special meeting is thus called, the secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called.

**Section 5. Delegates.** Each component society shall be entitled to send to the House of Delegates each year, one delegate for each 75 members, and one for a major fraction thereof; but each component society which has made its annual report and paid its assessment as provided for in this Constitution and Bylaws, shall be entitled to one delegate.

The number of delegates to which any component society is entitled shall be determined by the number of active members of the component society on the membership rolls of the Illinois State Medical Society as of December 31 of the preceding year.

The term of office of a delegate shall begin January 1 following his election, and shall be for two years, or until his successor has been elected. Component societies with one delegate only, may elect for one year.

**Section 6. Registration.** Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the president and/or the secretary of the component society, stating that the delegate or alternate has been regularly elected to the House of Delegates.

A delegate or his alternate may be seated without credentials, provided he is properly identified by his county society and so certified to the secretary of the Illinois State Medical Society.

When a delegate and his alternate are unable to attend a specified meeting, the appropriate authorities of the component society concerned may appoint a substitute delegate and a substitute alternate who on presenting proper credentials, shall be eligible to regular membership in the House of Delegates.

A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until final adjournment of that meeting. If a delegate, once seated, is unable to be present for reasons acceptable to the Committee on Credentials, an alternate may be certified by that Committee. After the alternate has been seated, he cannot be replaced.

**Section 7. AMA Delegates and Alternate Delegates.** The House of Delegates shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

**Section 8. District Divisions.** The House of Dele-

gates shall divide the state into districts, specifying which counties each district shall include.

**Section 9. Committees.** The House of Delegates may authorize the appointment of ad hoc committees by the president, who shall first consult with the president-elect.

The president shall have authority to designate to serve on ad hoc committees, members of the Society who are not members of the House and who may be present and permitted to participate in the debate when the report of the committee is considered.

#### CHAPTER IV. ELECTION OF OFFICERS

**Section 1. Officers.** The officers of this Society shall consist of the president, president-elect, first and second vice presidents, secretary-treasurer, speaker and vice speaker, sixteen trustees and one trustee-at-large.

**Section 2. Elections.** All elections shall be by ballot except when there is only one candidate for a given office, then election may be by voice vote.

The majority of votes cast shall be necessary to elect.

The election of officers, delegates and alternate delegates to the AMA, shall follow the completion of action on current and old business at the final session of the House of Delegates.

**Section 3. Terms of Office.** The president-elect, vice presidents, secretary-treasurer, the speaker and vice speaker shall be elected annually by the House of Delegates to serve for a term of one year.

Members of the Board of Trustees shall be elected by the House of Delegates to serve for a term of three years.

The speaker and vice speaker shall not be elected for more than three consecutive terms to their respective offices; they shall be elected from the membership of the House of Delegates.

The president-elect shall be inducted into the office of president by the retiring president during the final session of the House of Delegates. After assuming office at the adjournment of the annual business meeting, he shall continue in office until his successor has been elected and installed. Following his retirement as president, he shall automatically become a trustee-at-large for a term of one year.

#### CHAPTER V. DUTIES OF OFFICERS

**Section 1. The President.** The president of the Illinois State Medical Society shall lead the Society in all its functions. He shall deliver an annual address at such time as may be arranged, and perform such other duties as custom and parliamentary usage may require.

The president shall appoint the ad hoc committees of the House of Delegates. He may seek the advice of the officers and trustees.

He shall preside at the general scientific meetings



of the Society or designate one of the vice presidents to substitute for him.

Section 2. *The Vice Presidents.* The vice presidents shall act for and perform such duties for the president as he shall direct. They shall, when so acting, implement and advance the programs and policies of the president.

In the event of the president's death, resignation or removal from office, the first vice president shall succeed to the presidency.

In the event of a vacancy in the office of first vice president, the president shall fill the office by appointment.

Section 3. *Successor to President-Elect.* In the case of death, resignation, or removal from office of the president-elect, the office shall be filled by the House of Delegates at the next annual convention by election at a time recommended by the Reference Committee on Rules and Order of Business.

Section 4. *The Speaker.* The speaker, who shall be versed in parliamentary procedure, shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He shall appoint the reference committees.

He shall be an ex-officio member of the Committee on Constitution and Bylaws.

Section 5. *The Vice Speaker.* The vice speaker shall preside for the speaker in the latter's absence or at his request. In case of death, resignation or inability of the speaker to perform his duties, the vice-speaker shall serve during the unexpired term.

Section 6. *The Secretary-Treasurer.* In addition to the rights and duties ordinarily devolving on the secretary of a corporation by law, custom or parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, the secretary-treasurer shall be the official custodian of all securities and the income therefrom, owned by the Society, subject to the direction and disposition of the Board of Trustees. He shall be a member of the Finance Committee of the Board of Trustees.

The Board of Trustees may select a bank or trust company to act as custodian in the place of the secretary-treasurer, of all or any part of such securities and to act as agent of the Society in collecting the income therefrom.

The secretary-treasurer shall give bond in such sum as may be fixed by the Board of Trustees, the premium on such bond to be paid by the Society. He shall perform such other duties as may be directed by the House of Delegates or by the Board of Trustees.

In the event of a vacancy in the office of the secretary-treasurer, the Board of Trustees shall fill the vacancy until the next annual election.

## CHAPTER VI. THE BOARD OF TRUSTEES

Section 1. *Composition.* The Board of Trustees shall consist of sixteen trustees elected by the House of Delegates [six shall be chosen from district number three, and one from each of the other ten districts (see map attached), these districts of the geographical area as of May, 1946], and one trustee-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect, the speaker and secretary-treasurer.

The vice presidents and vice speakers shall attend the meetings (including executive sessions), with the right of discussion, but without the right to vote.

Section 2. The duties of the Board of Trustees are executive, custodial and judicial.

A. *Executive Duties.* The Board of Trustees shall implement all mandates from the House of Delegates except in matters of property or finance when it shall have sole authority.

The Board of Trustees may request a report from any committee in the interim between meetings of the House of Delegates.

B. *Custodial Duties.* The Board of Trustees shall have charge and control of all property of whatsoever nature belonging to the Society, and of all funds from whatsoever source belonging to the Society.

No person shall expend or use for any purpose money belonging to the Society without the approval of the Board of Trustees.

All money received by the Board of Trustees and its agents, resulting from the duties assigned them, shall be paid into the treasury of the Society, and all orders on the treasury for disbursement of money shall be approved by the Board.

The Board of Trustees shall formulate rules governing the expenditure of money to meet the necessary running expenses and fixed charges of the Society.

All acts of the House of Delegates involving the expenditure, appropriation or use in any manner of money, or the acquisition or disposal in any manner of property of any kind belonging to the Society, must be approved by the Board of Trustees before same shall become effective.

Funds may be appropriated to encourage scientific investigation, medical education or any other purpose deemed proper and approved by the Board of Trustees.

C. *Judicial Duties.* The Board of Trustees shall be the board of censors of the Society. It shall have jurisdiction over all questions of ethics and in the interpretation of the laws of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to component societies, or to this Society.

All questions of an ethical nature before

the House of Delegates or the general scientific meetings, shall be referred to the Board of Trustees without discussion. The Board shall hear and decide all questions of procedure affecting the conduct of members on which an appeal is taken from the decision of a component society.

The decision of the Board of Trustees shall be final except that an appeal may be taken by a member charged with misconduct as provided for in the Constitution and Bylaws of the American Medical Association.

Section 3. *Executive Administrator.* The Board of Trustees shall employ an executive administrator (who, when he shall be a physician, may be designated as the executive vice-president) whose duties shall be determined by the Board. He shall be responsible to the chairman of the Board. The Board shall review at each of its meetings the interim activities of the administrator. The Board shall also employ such other people as are needed for the conduct of the affairs of the Society.

Section 4. *Meetings.* The Board of Trustees shall meet daily during the annual convention of the Society, and at such other times as necessity may require, subject to the call of the chairman, or on the petition of the majority of the Trustees.

Section 5. *Organization.*

A. *Chairman.* The Board of Trustees shall meet on the last day of the annual convention and elect from among its members a chairman. He shall hold office for one year and may succeed himself for one additional year.

B. *Duties of the Chairman.* The chairman of the Board of Trustees shall prepare an agenda and shall preside at all meetings of the Board. He shall make an annual report to the House of Delegates. He shall be chairman of the Executive Committee. He shall present the report of the actions of the Executive Committee to the Board.

C. *Committees.* The Board shall form the following committees within itself:

- (1) Executive Committee
- (2) Finance Committee
- (3) Policy Committee
- (4) Ethical Relations Committee
- (5) Committee on Committees
- (6) Committee on Constitution and Bylaws
- (7) Committee on Publications
- (8) Advisory Committee to Woman's Auxiliary
- (9) Such others as deemed necessary.

D. *Duties of the Committees.*

- (1) *Executive Committee.* The Executive Committee shall consist of the president, the president-elect, the chairman of the Board, the chairman of the Finance Committee, the chairman of the

Policy Committee, the secretary-treasurer and the trustee-at-large.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy Committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

- (2) *Finance Committee.* The Finance Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

The Medical Benevolence Committee shall be a subcommittee of the Finance Committee. It shall:

- (a) Examine applications to the Society for assistance to determine eligibility for assistance.
- (b) Keep the names of the beneficiaries confidential and known only to the committee.
- (c) Recommend to the Finance Committee the allotment for each recipient, and
- (d) If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

- (3) *Policy Committee.* The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society.

- (4) *The Ethical Relations Committee.* The Ethical Relations Committee shall be constituted and function as stipulated in CHAPTER XII. DISCIPLINE. Part 2 Illinois State Medical Society procedures, Section 7.

- (5) *The Committee on Committees.* The Committee on Committees shall re-



view annually the purpose, activity and structure of all committees, and shall recommend such changes in existing committees or propose such additional committees as appear to be required for the efficient conduct of the business of the Society.

The activities of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

(6) *The Committee on Constitution and Bylaws.* The Committee on Constitution and Bylaws shall:

- (a) Receive from individual members, county societies, committees, the Board of Trustees, and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws;
- (b) Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws; and
- (c) Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

(7) *The Committee on Publications.* The Committee on Publications shall be composed of members of the Board of Trustees, and shall be responsible for the production of the Illinois Medical Journal.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the Journal. It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the Journal.

It shall review, edit and approve all material published by the Society.

(8) *Advisory Committee to the Woman's Auxiliary.* The Advisory Committee to the Woman's Auxiliary shall consist of the president elect as chairman, the president and the chairman

of the Board of Trustees.

The Committee shall provide advice and assistance to the president of the Woman's Auxiliary in her program for the year, and shall assist her in interpreting the activities of the Illinois State Medical Society.

Section 6. *Quorum.* Ten members of the Board of Trustees shall constitute a quorum for the transaction of business.

Section 7. *County Societies.* The Board of Trustees shall have authority to organize the physicians of two or more counties into societies to be suitably designated, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 8. *Publications.* The Board of Trustees shall provide and superintend the publication and the distribution of all proceedings, transactions and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary.

Section 9. *Bonding.* The Board of Trustees shall provide at the expense of the Society, adequate bond for those officers and employees of the Society it considers require bonding.

Section 10. *Duties of Trustees.* Each trustee shall be the organizer, consultant, advisor, administrator and speaker for the members of his district, and represent the Society as well as the members of his district at the Board meetings.

Each trustee should visit the societies in his district at least once a year. He shall make an annual report of his work and the condition of the profession in each society in his district to the Board of Trustees and to the House of Delegates.

Where his district is composed of more than one county, the trustee shall be an ex-officio member of the district Ethical Relations Committee, Grievance Committee, and Prepayment Plans and Organizations Committee. He shall report to the Board of Trustees the actions of the component societies on reports of these committees.

The necessary traveling expenses incurred by such trustee in the line of the duties herein imposed, may be allowed by the Board of Trustees upon presentation of a properly itemized statement.

Section 11. *Vacancies.* If during the interval between two annual conventions, sickness, death, or removal from the state or district, or any other reason prevents a trustee from attending the duties of his district, or if he shall be absent from two consecutive meetings of the Board, his office may be declared vacant at the discretion of the Board. The Board shall have the authority to fill

the vacancy for the period between the date at which the office was declared vacant and the next annual meeting of the House of Delegates.

Section 12. *The Benevolence Fund.* Each year the Board shall appropriate from the funds of this Society such sum or sums as it may deem proper to be held in a fund to be known as "The Benevolence Fund." This fund is established and shall be used only for the assistance or relief of needy members of this Society, their widows, widowers, or minor children. The assets shall be held in the treasury of this Society in a separate fund. Donations or bequests to the Benevolence Fund automatically become a part of these assets.

Section 13. *Audit and Financial Statement.* The Board of Trustees shall employ annually a certified public accountant to audit all accounts of the Society, and present a statement of same in its annual report to the House of Delegates.

This report shall also specify the character and cost of all publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

#### CHAPTER VII. DISTRICT COMMITTEES

Each trustee district which is composed of more than one county, shall have an Ethical Relations Committee, a Grievance Committee, a Committee on Prepayment Plans and Organizations, and such other committees as required to provide to each component society, those services the component society may not be able to provide for itself. District committees shall function only at the request of a component society within the district.

Complaints initially received by district committees shall be referred immediately to the component society for action.

District committees shall be governed by the procedural rules and regulations governing the counterpart state society committee or by these Bylaws.

Reports of findings and recommendations of these district committees shall be made to the component society which requested action.

The district trustee shall include a summary of the activities of each of these committees and the findings in general, in his annual report to the House of Delegates.

The committee members shall be elected, subject to the general rules on composition of committees contained in Section 5, Chapter IX, of these Bylaws, at a meeting of the delegates of the district called by the trustee of the district, before or during the annual convention of the Illinois State Medical Society. Chairmen of the committees shall be designated by the trustee of the district, and the trustee shall be an ex-officio member of each committee.

#### CHAPTER VIII. DUES AND EXPENSES

Section 1. *Annual Dues.* Assessments may be levied by the House of Delegates on each component society on a proportional basis. The amount of the dues shall be fixed by the House of Delegates and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association.

These annual dues shall include the annual subscription to the Illinois Medical Journal which shall be at least fifty per cent of the regular subscription price of the Journal.

Section 2. The Board of Trustees upon recommendation of the component society, shall give 50% reduction in dues to teaching, research and administrative personnel in full time employment in the approved medical schools in Illinois, or similar not-for-profit institutions in Illinois.

Section 3. Physicians in private practice of medicine may be given a 50% reduction in dues during the first year of practice upon recommendation of their component society.

Section 4. Physicians approved for membership after June 30 shall pay one-half of the annual dues for that year.

Section 5. The Board of Trustees may authorize the remission of dues of any member on recommendation of his component society for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association.

#### CHAPTER IX. COMMITTEES

Section 1. *Committees of the Illinois State Medical Society.* The committees of the Illinois State Medical Society shall be:

- A. Standing committees called Councils
- B. Reference committees
- C. Ad hoc committees
- D. Board of Trustees committees

Section 2. *Standing Committees-Called Councils.*

The standing committees of the Society shall be:

- A. Medical-Legal Council
- B. Council on Legislation & Public Affairs
- C. Council on Education and Manpower
- D. Council on Economics and Governmental Health Programs
- E. Council on Environmental and Community Health
- F. Council on Public Relations and Membership Services
- G. Council on Mental Health and Addiction
- H. Council on Social and Medical Services;

and such other Councils shall be established from time to time by the Board of Trustees.

Section 3. *Organization of Councils.*

- A. Councils shall be appointed by the Board of



Trustees.

- B. The chairman of a Council shall be designated by the Board. He may not serve as chairman of any committee of the Council.
- C. Each Council shall have authority to request the Board of Trustees to appoint sub-committees for any purpose within the functions of the Council. A member of the Council shall be designated as chairman of the sub-committee.
- D. These sub-committees may also request the Board to appoint special committees for any purpose relating to the general functions of the sub-committee. A member of the sub-committee shall chair the special committee.
- E. Only active members of the Illinois State Medical Society, not American Medical Association delegates nor those holding elective office in the Illinois State Medical Society, may be appointed to a Council. Any active member of the State Society may be a member of a sub-committee or a special committee. Elective officers may be appointed advisors to any committee.

Recommendations for membership on any committee may be submitted to the Board of Trustees by the House of Delegates, or in writing by any member of the Society.

A state committee which reviews the decisions of a similar committee of a component society may not have as a member one who currently serves on the same committee of a component society or district.

- F. Each Council, sub-committee or special committee shall have authority to make rules to govern its procedures subject to:
  - (1) Specific requirements of the Constitution and Bylaws and the policies of the House of Delegates, and
  - (2) Approval of the Board of Trustees.
- G. Each Council shall submit for adoption, a budget for the ensuing year, and the Board of Trustees shall determine the appropriation for each Council. Requests for additional funds must be approved by the Board before they are committed.
- H. The president of the Society, the speaker of the House and the chairman of the Board shall be ex-officio members of the various Councils, and may attend all committee meetings.
- I. Each Council shall have members in sufficient quantity so that each sub-committee may be chaired by a different member.
- J. Terms of office of members of the Councils shall not be more than three years, but may be terminated for cause at any time at the discretion of the Board. No member of a Council shall serve more than three consecutive terms. Service of two or more years in

an unexpired term shall be considered a full term.

#### K. Reports.

- (1) Special committee reports shall be made by the chairman to the sub-committee from which he was appointed.
- (2) Reports from sub-committees (which shall contain summaries of the report of special committees) shall be made by the chairman to the Council of which he is a member.
- (3) Reports of Council activities shall include recommendations on reports and requests from sub-committees, and shall be made to the Board of Trustees by the chairman of the Council.
- (4) The Chairman of the Council with the approval of the Board, may permit any member of a committee under the Council to clarify the report of that committee to the Board.
- (5) The Chairman of any committee may request the Board of Trustees to allow him, or any member of his committee, to appear before the Board.
- (6) All committees shall submit to the House of Delegates, written reports summarizing all actions, and may include recommendations for House consideration.

- L. Vacancies on any committee may be filled at any time by the Board of Trustees. Committee membership may be enlarged or decreased or the committee may be discharged by the Board of Trustees.

#### M. Committee Meetings

The chairman of a committee, when he considers it expedient and with the consent of two thirds of the members of the committee, may conduct business or hold meetings by mail or by conference call, provided all members of the committee are given opportunity to participate, that minutes of the transactions are recorded, approved by members participating, and circulated among all committee members.

#### Section 4. Duties (Area of Concern)

- A. The Medical-Legal Council shall be concerned in the areas of:

- 1. Liaison with the Illinois Bar Association
- 2. Liaison with courts, particularly where improper medical testimony is involved
- 3. Implementation of the Impartial Medical Testimony Rule
- 4. Legal aspects of medical practice other than in the area of mental health
- 5. Licensing and standards of practice
- 6. Quackery
- 7. Anatomical gifts and organ transplants

- B. The Council on Legislation and Public Affairs shall be concerned in areas of:
1. Federal and state legislation—analysis and communication
  2. Legislative liaison—both state and federal
  3. Political education
- C. The Council on Education and Manpower shall be concerned in the areas of:
1. Liaison with medical schools, curricula, etc.
  2. Health manpower and training
  3. Postgraduate education
  4. Internships, residencies, etc.
  5. Scientific assembly
  6. Student loans
  7. Liaison with Student American Medical Association
  8. Continuing Medical Education
- D. The Council on Economics and Governmental Health Programs shall be concerned in the areas of:
1. Relations with governmental purchase of care programs (Medicare, Medicaid, Vocational Rehabilitation, etc.)
  2. Relations with prepayment, insurance and other third party plans
  3. Fees and fee adjudication as promulgated by the Usual and Customary Fee Committee
  4. Health care cost and utilization
- E. Council on Environmental and Community Health shall be concerned in the areas of:
1. Governmental administrative regulation—Departments of Health
  2. Public Safety
  3. Occupational Health
  4. Child and School Health
  5. Pollution
  6. Nutrition
- F. Council on Public Relations and Membership Services shall be concerned in the areas of:
1. Publicity and promotion
  2. Media relations
  3. Exhibits and public service programming
  4. Religion and medicine
  5. Illinois State Medical Society sponsored membership insurance programs
  6. New member orientation and membership benefit explanation
  7. Fifty Year Club
- G. Council on Mental Health and Addiction shall be concerned in the areas of:
1. Facilities and services
  2. Liaison with Department of Mental Health
  3. Legal aspects of commitment, etc.
  4. Narcotics and dangerous drugs
  5. Alcoholism
- H. Council on Social and Medical Services shall

be concerned in the areas of:

1. Health care facilities and services
2. Emergency and disaster care
3. Liaison with other health professional and health oriented organizations
4. Relations with specialists not otherwise assigned
5. Problems of aging
6. Rural Health

#### Section 5. *Reference Committees*

Reference Committees shall be appointed by the speaker of the House of Delegates as outlined in Chapter X. REFERENCE COMMITTEES, and as provided therein.

#### Section 6. *Ad hoc Committees*

- A. Ad hoc committees shall be appointed by the speaker of the House of Delegates to accomplish specific duties.
- B. Any member of the Society may be asked to serve.
- C. The terms of appointment shall be for the duration of the task, or until the committee shall be discharged.
- D. Ad hoc committees expected to serve for more than three years, shall be reorganized and given the status of a sub-committee or special committee under the appropriate Council and should be appointed by the Board of Trustees.
- E. Between meetings of the House of Delegates ad hoc committees shall report to the Board of Trustees keeping it informed of all current activities.

#### Section 7. *Board of Trustees Committees*

These committees are detailed in CHAPTER VI. THE BOARD OF TRUSTEES Section 5 (D).

### CHAPTER X. REFERENCE COMMITTEES

Section 1. *Appointment.* Immediately after the organization of the House of Delegates at each annual or special meeting, the speaker shall announce the appointment from among the members of the House, such committees as may be deemed expedient by the House of Delegates.

Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.

Section 2. *Duties of Reference Committees.* References, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which shall report to the House of Delegates before final action shall be taken. A two-thirds affirmative vote of the House of Delegates shall be required to suspend this rule.

Section 3. *Organization.* Each reference committee shall, as soon as possible after the adjournment of each session, or during the session if necessary, take up and consider such business as may have



been referred to it, and shall report on same at the next session, or when called upon to do so.

Section 4. *Reference Committees.* The following committees are hereby provided for:

A Committee on Credentials

A Committee on Rules and Order of Business  
Tellers and Sergeants-at-Arms

A Committee on Changes in the Constitution  
and Bylaws

and such other committees as the speaker shall deem necessary to conduct the business of the House, or consider the reports of officers, trustees, executive administrator, the reports of committees pertaining to administrative activities, economics activities, scientific activities, public relations activities and legislative activities, as well as such resolutions, reports, and proposals as shall be brought before the House of Delegates.

Section 5. *The Committee on Credentials* shall consider all questions regarding the registration and the credentials of the delegates. It shall pass out and receive the attendance slips for each session of the House of Delegates, and perform any other duties assigned.

Section 6. *A Committee on Rules and Order of Business* shall consider all matters regarding rules governing action, method of procedure and order of business for the House of Delegates.

Section 7. *The Tellers and Sergeants-at-Arms* shall

A. Serve the speaker of the House of Delegates

B. Distribute, collect and tally votes when a ballot is taken, or a numerical tally is required

C. Certify those in attendance in closed or executive sessions of the House of Delegates.

Section 8. *The Committee on Changes in Constitution and Bylaws* shall consider all proposed amendments to the Constitution and Bylaws.

The chairman of the Committee on Constitution and Bylaws, or his representative, shall serve in an advisory capacity to this reference committee and shall attend all sessions, including the executive sessions of the reference committee, to assist in the preparation of the report of the committee of the House of Delegates.

## CHAPTER XI. COUNTY SOCIETIES

Section 1. All county societies now in affiliation with this Society, or those which may hereafter be organized in this state, which have adopted principles of organization in harmony with this Constitution and Bylaws, shall upon application to and approval by the Board of Trustees, receive a charter from and thereby become a component part of this Society, and members thereof shall become members of this Society and the American Medical Association.

Section 2. Charters shall be issued only on approval of the Board, and shall be signed by the president and the secretary of this Society.

The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Section 3. Only one component medical society shall be chartered in any county.

Section 4. Every registered physician holding the title of Doctor of Medicine or its equivalent, who either (1) resides in the jurisdiction of a component society, or (2) resides in a state other than Illinois but practices principally in the jurisdiction of a component society and who is of good moral character and professional standing, shall be eligible to membership in that component society.

The component county society shall be the sole judge of the qualifications of its members, subject only to the stipulations contained in the Constitution and Bylaws.

Section 5. Any physician who has been disciplined by any action of a component society and believes he has not had a fair trial, shall have the right of appeal to the Board of Trustees.

Section 6. When a member in good standing in a component society changes his residence to another county in this state, such change of residence shall terminate his membership in such component society. (This ruling shall not apply to members in military service or in the service of the State or the United States government.)

Such member shall be entitled, upon his request, to a statement from his former secretary as to his standing. This statement of standing shall be issued without cost to the applicant.

He shall present this statement to the component society of the county to which he removes and it shall accompany his application for membership. The board of censors of the society receiving this application shall give this statement of prior standing due consideration before accepting or rejecting his application for membership.

Section 7. A physician living on or near a county line, or practicing partly or totally in an adjacent county, may hold his membership in the county most convenient for him, provided he submits written authorization to that society from the component society in whose jurisdiction he resides.

Section 8. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such a roster the secretary shall note any changes in the personnel of the profession by death or by removal to or from the county. When requested, he shall furnish on blanks supplied him for the purpose, an official report containing such information for the secretary of this Society and likewise for the trustee of the district in which his county is situated.

Section 9. The secretary of each component society shall forward its roster of officers and members, and a list of delegates and alternate delegates to the secretary of this Society before the fifteenth of January each year.

Section 10. Any component society which fails to pay its assessment or make the annual report required on or before March fifteenth shall be held as suspended and none of its members shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.

A member is in good standing unless otherwise disqualified, whose dues are paid on or before the first day of March of the current year. Immediately after the first of March, each delinquent member shall be notified that in consequence of non-payment of dues, his membership is delinquent. If dues remain unpaid as of June thirtieth of the current year, membership shall be dropped automatically. The member may be reinstated by paying all delinquent dues, provided, in the interim, he has not been guilty of conduct prejudicial to membership; but if two or more years have elapsed since he was a member in good standing, he must in addition, make application as a new member.

Section 11. The Constitution and Bylaws of the Illinois State Medical Society and of the American Medical Association, together with the Principles of Medical Ethics of the American Medical Association, shall be binding upon the members of the component societies.

## CHAPTER XII. DISCIPLINE

### PART 1. COMPONENT SOCIETY PROCEDURE

Section 1. *Local Ethical Relations Committee.* Each component society may have, either by appointment or election, an Ethical Relations Committee, whose duty it shall be to prosecute formal charges of unethical conduct. In the event that the county society does not have such a committee, the district Ethical Relations Committee shall function in its behalf.

All parties may have legal counsel present to advise and counsel them during the proceedings, but such counsel may not participate in the proceedings, shall be expected to be helpful to all parties concerned, shall not be contentious, may not participate in judgment and who may be excluded from the hearing by the chairman or by vote of the committee.

The component society (or district) Ethical Relations Committee may establish reasonable rules of procedure, and they shall not be bound by the technical rules of evidence as the same pertain in courts of law. In all proceedings before such Ethical Relations Committees, the complainant, the accused and all witnesses before the committee shall be placed under oath.

Proceedings shall be in the form of "peer re-

view" in which representative physician members of the county medical society shall evaluate acts by the standards established and amended by the House of Delegates of the American Medical Association (specifically known as the Principles of Medical Ethics of the American Medical Association), and by such additional standards as shall be incorporated in the Constitution and Bylaws of the Illinois State Medical Society and/or the county medical society, by local customs and traditions, and subscribed to by specific consent or implied consent through continued membership in the Society.

Section 2. *Offenses.* Any member of a component society shall be subject to censure, suspension or expulsion by such component society when

- A. He has been adjudged guilty by proper civil authorities of a criminal offense involving moral turpitude, or
- B. He has been adjudged guilty by his component society in accordance with the procedural requirement of these bylaws:
  - (1) of a gross misconduct as a physician or surgeon, or
  - (2) of a violation of the Constitution or Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association.

Section 3. *Charges Initially Presented to the Illinois State Medical Society.* Original complaints received by the Illinois State Medical Society should be referred directly to the secretary of the component society of which the accused is a member and to the appropriate district Ethical Relations Committee.

Section 4. *Principles of Justice.* The following principles of justice shall guide the Ethical Relations Committee in all disciplinary procedures.

- A. An accused is presumed to be innocent until he has been proven guilty.
- B. Formal charges before the Ethical Relations Committee of the component society or district Ethical Relations Committee must be presented under oath by the complaining party.
- C. After formal charges have been preferred there shall be no evasion of the fact that the respondent is to be tried; that the Ethical Relations Committee before which he is cited to appear is a trial body and that he will be on trial when he appears.
- D. He must be notified by certified mail of the specific charges which are made against him at least ten days before the date set for his trial.
- E. He may not be found guilty of anything not included in the charges preferred against him and presented to him.
- F. All evidence not pertinent to the charge as



made shall be considered irrelevant and immaterial . . . it shall be wholly disregarded in the decision.

G. Testimony not bearing on the charges shall be objected to and if sustained by the trial body, stricken from the records.

H. The respondent shall be advised of his rights by the trial body, namely: (1) that he may be represented by any member of the society as counsel and that he may have legal counsel present; (2) that he may cross examine witnesses; (3) that he may offer in evidence any records or documents that he deems fit; (4) that he may enter objections as to testimony or to material offered in evidence; (5) that he may address the trial body in his own behalf; (6) and that he has the right of appeal to the Board of Trustees of the Illinois State Medical Society.

Section 5. *Records.* A comprehensive stenographic record of the proceedings must be kept for reference, and shall be available until final adjudication has been made.

In the event of an appeal being taken from the verdict of the local or district Ethical Relations Committee, the stenographic record shall be forwarded by certified mail to the Board of Trustees of the ISMS ten days prior to the date the appeal is to be heard. Failure to provide such records shall be grounds for a verdict of default against the component society.

Section 6. *Verdict.* The committee, sitting as a trial body, shall find the accused either guilty or not guilty. If the verdict is guilty, the trial body shall recommend censure, suspension or expulsion.

The findings of the trial body must be presented to the component county society for approval or rejection. The accused must be notified by certified mail at least ten days before the date set for the meeting at which this action will be taken. If the findings of the trial body are against the accused the secretary of the component society shall acquaint the accused, by certified mail, with his right of appeal within thirty days to the Board of Trustees of the Illinois State Medical Society.

## PART 2. ILLINOIS STATE MEDICAL SOCIETY PROCEDURES

Section 7. *Illinois State Medical Society Ethical Relations Committee.* The Board of Trustees shall appoint from its members, an Ethical Relations Committee to review matters involving the interpretation of the Principles of Medical Ethics, violations of the Constitution and Bylaws of the Illinois State Medical Society or its component societies, and charges of misconduct of members of the Society.

It shall serve as an appellate body to review

cases involving these matters referred by component medical societies, and shall consider matters of law (ethics) and procedure.

Section 8. *Appeals from Component Society Verdicts.* Appeals received by the Illinois State Medical Society Board of Trustees shall be referred to the Ethical Relations Committee of the Board for review. Appeals must be accompanied by pertinent data and transcripts indicating the basis for the appeal. Failure to provide such data shall be grounds for a verdict of default against the plaintiff. The committee shall notify the accused and the secretary of the component society by certified mail at least thirty days prior to the date set for the hearing of the appeal. The chairman of the committee shall preside over the hearing in accordance with the rules established by the Board of Trustees.

Section 9. *Verdict.* On conclusion of the hearing, the Ethical Relations Committee of the Board of Trustees shall meet in executive session to consider its decision, and shall report in writing to the Board at its next meeting for approval or rejection.

Section 10. *Notification of Parties.* The secretary of the Society shall notify the defendant and the secretary of the component society wherein the defendant holds membership, of the action of the Board.

A. *Right of Appeal to the American Medical Association.* In case of findings against the accused, and in support of the action taken by the component society, the secretary of the state society shall notify the accused within ten days by certified mail of his right to appeal to the Judicial Council of the American Medical Association.

B. *Error.* In the event of a decision by the Board of Trustees of improper law (ethics) and/or procedure by the trial body of the component society, the case shall be remanded with recommendations to the component society for reconsideration.

## CHAPTER XIII. MISCELLANEOUS

Section 1. The fiscal year of this Society shall be from January 1 to December 31 inclusive.

Section 2. Robert's "Rules of Order, Revised," shall be the guide for all procedure when not in conflict with the Constitution and Bylaws.

## CHAPTER XIV. AMENDMENTS

The House of Delegates may amend any article of these Bylaws by a two-thirds vote of the delegates present at any meeting, provided that such amendment shall not be acted upon before the day following that on which it was introduced.

## **Order of Business of the House of Delegates**

### **FIRST SESSION**

1. Call to order.
2. Report of Committee on Credentials.
3. Roll Call.
4. Reading and approval of minutes of last meeting.
5. Appointment of Reference Committees.
6. Reports of Officers.
7. Reports of the Trustees, the Editor, etc.
8. Reports of Standing Committees.
9. Reports of Board Committees.
10. Reports of Special Committees.
11. Reading of Resolutions.
12. Unfinished Business.
13. New Business.
14. Recess.

### **LAST SESSION**

1. Call to order
2. Report of Committee on Credentials
3. Roll Call
4. Reports of Reference Committees
5. Fixing of per capita tax for ensuing year
6. Selection of meeting place for next annual meeting. (Subject to the investigations of the Board.)
7. Unfinished business
8. Election of
  - (a) officers
  - (b) trustees
  - (c) delegates to the AMA
  - (d) alternate delegates to the AMA
9. Induction of President Elect into the office of President
10. New business
11. Adjournment (sine die)



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# *Policy Manual of the Illinois State Medical Society May 1969*

"Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience."

"Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy."

This manual shall be a guide for officers, trustees, committee chairmen and headquarters staff to the stand taken by the House of Delegates of the Illinois State Medical Society on all issues involving Society policy.

Its statements shall combine and reconcile the best expressions made on all phases of policy involving the House of Delegates, the Board of Trustees and the various committees.

All policy statements (except those involving the funds of the Society) shall have the approval of the House of Delegates, since the Constitution and Bylaws provide in ARTICLE V:

"The House of Delegates shall set the basic policy and philosophy of the Society."

All policy statements developed during the interval between meetings of the House shall be submitted at its next meeting for action. The House may:

- (1) approve, amend, or reject—
- (2) refer the statement to the Board for reconsideration and subsequent report—
- (3) remand the statement to the committee from which it came for further study and report.

Policy statements for the consideration of the House may appear as a portion of the annual report of the Policy Committee, or they may be contained in other reports to the House. The final statements for publication in this Policy Manual are to be prepared by the Policy Committee. Any member of the Illinois State Medical Society may submit a policy statement for consideration.

Temporary policy between meetings of the House is determined by the Board. Committees may request Board consideration at any time.

The Illinois State Medical Society shall support policy statements approved by the House of Delegates of the American Medical Association.

National policy is the prerogative of the national association. Until specific contrary action emanates from the AMA House of Delegates, the Board of Trustees and the officers of the ISMS shall consider all such policy as binding.

Policy action at the state level does not rescind official AMA rulings in Illinois, and the Society must recognize such policy until it has been changed at the national level.

The same "chain of command" should exist between the county medical society and the ISMS House of Delegates. Policy established at the State

Society level must prevail until majority action by the House of Delegates has rescinded or reversed the statements. This represents "majority rule" and must be followed closely to preserve the democratic processes.

## **Alcoholism**

"Since alcoholism has been widely regarded as a disease for some time and because it is impossible to differentiate immediately between a chronic alcoholic and any other intoxicated person, the individual who is acutely ill from alcohol ingestion should be considered a health problem and therefore be adjudicated within the purview of the medical and other health professions."

## **Assessments**

Compulsory assessments of members of hospital staffs for any purpose are unethical and improper.

## **Athletic Programs**

Children of school age, through the 9th grade, should not participate in body contact sports.

Elementary school children develop better physically if activities are informal and not highly competitive.

Medical supervision of all athletic programs is essential.

## **Audits & Surveys**

### **(Hospital, nursing homes, etc.)**

Audits and surveys which impinge on personal privacy, patient care and local hospital trustee and medical decisions as to management should not be condoned.

## **Autonomy of County Medical Societies**

No ruling of any county medical society shall conflict with the Principles of Medical Ethics of the American Medical Association, or with the Constitution and Bylaws of the Illinois State Medical Society.

In all other areas, the county society shall be autonomous.

## **Birth Certificates**

Birth certificates should contain only such items as are pertinent to their function. Information recorded on birth certificates should not be provided to organizations or individuals for other than approved purposes.

## **Budgets—(see "Financial Policies")**



## **Committee Appointments**

The chairman of the Board of Trustees and the officers of ISMS shall give the trustees an opportunity to recommend physicians from their districts for appointment to various committees. Trustees shall receive the proposed list of committee appointments for their consideration and review prior to the meeting of the Board at which the final committee personnel is to be approved.

Elective committees should serve for uniform terms of office—preferably three years. These terms of office should be held on a staggered basis to provide continuity in the committee structure. Individual tenure on any committee should be limited to a maximum of nine years of continuous membership—whether elected or appointed.

Physicians appointed to an Illinois State Medical Society committee must be members in good standing of this Society.

## **Communicable Diseases**

Physicians, especially those engaged in public health work, should enlighten the public concerning all regulations and measures for the prevention and control of communicable diseases. When an epidemic prevails, a physician shall continue his labors without regard to his own health.

## **Community Health Week**

The medical profession shall provide the scientific leadership to focus attention on the health needs of the community and to encourage and assist in developing Community Health Week activities.

## **Conflict of Interest**

When a case of conflict of interest arises and is self-evident, by the attitude shown by the individual concerned, it should be referred to the Executive Committee of the Board of Trustees of the ISMS for consideration.

## **Constitution and Bylaws**

Final copy of any changes made by the House of Delegates in the Constitution and/or the Bylaws shall be prepared for publication by the Committee on Constitution and Bylaws, in consultation with legal counsel, making sure that the published changes reflect the thinking expressed by the action of the House.

## **Continuing Education**

Continuing education shall be one of the basic purposes of the Illinois State Medical Society for scientific advancement, humanization of medicine, improvement of medical public relations, and development of cooperation and rapport with the public.

## **Co-operation with the American Medical Association**

Actions of the AMA House of Delegates are binding upon its membership at all levels, county, state and national.

(Since all members of the Illinois State Medical Society are also members of the American Medical

Association, this is universally true in Illinois. The right to disagree, the right to protest, the right to become "the loyal opposition" is not questioned. However, until such time as the AMA House has reversed its decision, it is mandatory that the membership abide by the will of the majority.)

## **Cultists, Association with (Association with Osteopaths—see "O")**

The Judicial Council of the American Medical Association has ruled that it is unethical to associate VOLUNTARILY with an individual who practices as a member of a "cult."

## **Disaster Control**

Any disaster creates an obvious need for trained personnel to aid the sick and injured. Local medical societies should cooperate to provide medical self-help programs. County societies should provide training for their membership in the treatment of mass casualties, radiological casualties and in the organization, operation and maintenance of emergency hospitals.

## **Discrimination—(see "Freedom of Choice")**

## **Dues, Recommendation of the Board to the House**

The chairman of the Board of Trustees shall place the question of dues for the coming year on the agenda for consideration at the spring meeting of the Board.

Immediately following this meeting, written notice of the recommendation regarding dues for the next fiscal year, shall be mailed to all delegates and alternate delegates from the component societies, and also to all presidents and secretaries of county medical societies. This recommendation shall also be published in the Illinois Medical Journal as a part of the annual report of the Chairman of the Board.

## **Education, Primary and Secondary**

Primary and secondary education is a community problem. In order to retain jurisdiction of these grade schools, finances should be raised by taxation at the local level.

## **Ethics**

Cases involving ethics shall reach the state society level only by means of an appeal. As outlined in the Bylaws, the state society committee shall serve only as an appellate body to review such cases.

## **Examinations**

All physical examinations should be performed in the physician's office. No examinations should be conducted on a group basis unless authorization has been given by the local county medical society in a single instance or for a specific purpose.

This general statement does not apply to the industrial or occupational health physician in his in-patient activities.

## **Facility Medical Boards (Physicians)**

In all legislation which establishes boards for

the administration of medical facilities operated by governmental units, at least one-third of the board should be physicians licensed to practice medicine in all its branches.

### **Federal Funds**

When a federal government assistance program is essential it should be conducted under the administration and control of local government. The Society does not favor any federal assistance program which removes administrative control from the state or local level.

### **Fee Schedules**

No member or committee shall be permitted to approve a fee schedule for the Illinois State Medical Society until it has been submitted to and approved by the House of Delegates or the Board of Trustees.

Individuals covered by various fee schedules shall receive the best type medical care in all cases, and the physicians involved shall be remunerated according to the accepted fee schedule. Fees should be commensurate with services rendered.

### **Financial Policies**

(also see "Assessments," etc.)

(1) The Finance Committee is to make budgetary recommendations to the Board of Trustees; however, such recommendations must be approved by the Board.

(2) The expenses of any duly elected delegate or alternate delegate attending the meetings of the House of Delegates of the American Medical Association shall not be assumed by the ISMS until he enters his official term of office set by the Constitution and Bylaws of the AMA.

(3) The expenses of any official representative of the ISMS attending any authorized meeting shall be determined by the Finance Committee and approved by the Board of Trustees.

(4) Any new project authorized by House action requiring the expenditure of funds must be accompanied by an estimate of the cost and suggested methods of providing the necessary funds.

(5) Budgets submitted to the House by the Board should provide for the ensuing fiscal year.

(6) In addition to fixed reserves, the development of a contingency reserve is desirable.

(7) All financial records shall be available at headquarters office, and may be examined by any member of the Society. A semi-annual summary of the financial statements of the Society shall be mailed to any county society secretary or delegate if requested. A projected budget for the next fiscal year shall be mailed to the members of the House of Delegates at least 30 days prior to the annual convention. These reports shall be in the format customarily used in ordinary corporate practice.

### **Freedom of Choice**

The mutual right of physicians and patients to exercise freedom of choice in medical matters shall be maintained. This includes the right of the pa-

tient to choose the physician by whom he will be served, and the right of the physician (except in emergencies) to a corresponding freedom of choice. All members of the Illinois State Medical Society enjoy the same rights and privileges and are bound by the same obligations and standards of professional conduct.

### **Health Care—Ancillary Services**

All segments of our population are entitled to and shall receive the best health care available. The physicians in Illinois are encouraged to cooperate in the implementation of any national program meeting with the general policy statements of the Society. (This shall be interpreted to include health aspects in nursing home care, use of recreational facilities, environmental health, public health, employment problems, etc., and any other area which involves the health of the residents of this State.)

### **Health Care Costs**

The public should be educated concerning the difference between "health care costs" and "medical care costs." Members of the profession should cooperate with the various ancillary groups and should be able to explain the cost factors involved in total care.

### **Health Careers**

All capable and worthy individuals interested in medicine as a career shall be encouraged and assisted by the Illinois State Medical Society. Those interested in paramedical fields shall be provided with all pertinent information.

### **Hospitals**

Physicians should sponsor and assist in the development of all medical staff committees within the hospital.

The local medical profession should cooperate to achieve the accreditation of all eligible hospitals, and should encourage the stabilization or reduction of hospital costs in all areas where they have authority.

### **Hospital Assessments—See Assessments Hospital Committees (Dealing with physician-patient relationship)**

All committees dealing with the review of physician-patient relationship in hospitals and nursing homes are urged not to release findings to any third parties except by subpoena or court order. Any reports issued by the committees involved should be submitted to the chief of staff for his disposition.

### **Hospital Records and Their Availability**

Hospital records are privileged information and the property of the patient, kept in trust by the hospital. They are not to be released except on a court order.

Upon receipt of a request signed by the patient, an abstract or a summary shall be provided when needed, to insurance companies, governmental agencies, consulting physicians, etc.



## **Hospital Staff Privileges**

The medical staff of a hospital does not have the privilege or the right to make compulsory assessments of members of the medical staff for building funds, or to demand an audit of staff members' personal financial records as a requisite for staff appointments.

## **House of Delegates, Special Meetings of**

When a special meeting of the House of Delegates is scheduled which may involve an increase in dues or a special assessment, the call for that meeting shall contain specific notification of that possibility.

## **Immunization Program**

Illinois residents should be provided all types of immunization. Physicians are requested to provide this protection especially to all children, or to encourage the local public health agency to perform this function.

Every school should have a school health committee with at least one physician as a member. County advisory school health councils should assist in coordination.

## **Indigent, The Care of the**

Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and only in conjunction with the other levels of government in the order above.

The determination of medical needs should be made by a physician. The determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved.

## **Individual Rights**

Since this Society believes that a strong America is a free America, the rights of an individual, or a group of individuals, to openly express themselves cannot be condemned even if one is in complete disagreement, if the laws of the land are not violated. To support such condemnation would be inconsistent with this Society's basic philosophy.

## **Insurance Plans**

Physicians are urged to cooperate with voluntary health insurance plans approved by the Illinois State Medical Society.

Fixed fee schedules should not be accepted. All fees should be based upon the usual and customary fee concept.

Insurance programs for the membership of the Illinois State Medical Society should be studied and implemented by the proper committee. Major medical and comprehensive hospital group coverage should be part of this insurance package.

## **Journal Publication**

The Publications (Journal) Committee, with the approval of the Board of Trustees, has authority over the publication policy and the screening of all advertisers and advertising copy appearing in the Illinois Medical Journal.

## **Laboratories**

All laboratories providing medical data should be under the direct supervision of a physician.

## **Lay Employees and Their Prerogatives**

Policy is established by the House of Delegates.

Staff shall cooperate with officers and committee chairmen in setting up activities and in carrying out all necessary routine.

Staff also shall keep new officers and committee chairmen aware of policy statements, and assist them in the preparation of reports to the House of Delegates to:

- change existing policy
- establish new policy
- request House approval of committee projects and/or
- procedure involving policy.

Committees shall be informed of their right to set up operating rules and regulations.

## **Legal Counsel**

The legal counsel of the Illinois State Medical Society shall concern himself with official inquiries from officers, trustees, committee chairmen and county medical societies. Such inquiries shall be channeled through the Executive Administrator.

## **Legislation**

All matters pertaining to state or federal legislation shall be referred to the Legislative Committee for consideration and recommendation prior to Board of Trustees and/or House of Delegates action.

Matters pertaining to federal legislation shall be checked against recommendations or policies of the American Medical Association by the Council on Legislation of the Illinois State Medical Society prior to making a recommendation either to the Board of Trustees or to the House of Delegates.

Before any legislation is developed for presentation to the Illinois General Assembly, the proposed law shall be considered by the Council on Legislation, which shall work in close cooperation with any other Society committee involved. The instigating committee should determine the content of the law and the Legislative Council primarily should consider relationship of the proposed legislation to the total legislative program.

## **Mailing List**

The use of the mailing list of ISMS members must be approved by special action of the Board of Trustees.

## **Medical Care, Provision of**

Medical care shall be provided regardless of the

ability of the patient to pay. Physicians shall not refuse to render needed emergency care to any patient.

### **Medical Representation in Government Planning**

In health programs financed by government funding in an Illinois community, there shall be representation at the highest policy level by an official representative of the State Society and the appropriate county medical society involved. Remuneration for services in above programs shall follow the policies of the Illinois State Medical Society.

### **Membership in Paramedical and Service Organizations**

Membership in Chambers of Commerce (city, state and national) is to be encouraged. This policy extends to the individual physician as well as to the component societies.

Membership in the Illinois Association of the Professions is encouraged. Medicine should be well represented among these allied professional groups and the growth and development of the Association is of concern to ISMS economically, politically and scientifically.

The Society recommends that physicians affiliate with service clubs, local political action groups and participate to the fullest extent possible in affairs affecting the health and welfare of the residents of Illinois.

### **Mental Health**

Mental health planning should be implemented at the community level. County medical societies should be kept aware of their responsibilities to assist in developing improved mental health facilities.

A physician licensed to practice medicine in all its branches should be required to certify the discharge of any patient from a psychiatric institution.

### **Occupational Health**

Occupational health is an essential ingredient of employee welfare. The adoption and development of health programs in industry should be encouraged.

Occupational health will be advanced through the utilization of all physicians involved in industrial work.

### **Osteopaths, Association with**

Voluntary professional associations with a Doctor of Osteopathy are not deemed unethical if the Doctor of Osteopathy bases his practice on the same scientific principles as those adhered to by members of the American Medical Association and if he is licensed to practice medicine and surgery in all of its branches in Illinois.

### **Placement Service**

Before the Physicians' Placement Service recommends that a town in Illinois be listed as need-

ing a physician, it shall be established that the need actually exists; that the community can support a physician; that certain physical assets (office—home—schools, etc.) are available for the physician and his family.

The qualifications of the physician also shall be ascertained prior to furnishing him with the list of available areas in Illinois needing a physician.

### **Policy Statements**

Policy statements shall be defined as guide lines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience.

Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy.

### **Polls, Opinion**

The vote of the House of Delegates shall express the opinion of the majority of the Illinois State Medical Society membership. Since delegates are the duly elected representatives of their county medical societies and their voting reflects the thinking of their constituents, a majority opinion HAS BEEN expressed, and a membership poll becomes unnecessary except under very exceptional conditions.

### **Prepayment Plans and Organizations**

It is not within the province of ISMS to act in other than an advisory capacity when working with a "third party plan," and its best efforts should be directed toward supplying guidance, education and communications between the membership and the prepayment plans and organizations involved.

The principle of free enterprise as exemplified by private insurance companies and the "Blue" plans is to be endorsed.

### **Press**

All county medical societies should cooperate with the local press. The public should be provided with prompt and accurate information in all health fields; the source of this information should be the medical profession.

County medical societies should provide information at the local level; the State Society is responsible for press releases involving State Society officers or any official statements of the Society appearing in the press.

A code of ethics applicable to medicine and the fourth estate should be developed. (That used in the Decatur area has been given national recognition by the AMA.)

### **Publication of Research Data**

In releasing research material for publication in the Illinois Medical Journal, or any other media, extreme care should be exercised. The welfare and privacy of the patient, the professional reputation of the physician should be of primary concern.

If any question arises, consultation with the



Board of Trustees is suggested. All such inquiries should be addressed to its chairman.

### **Public Affairs**

No officer or member of the Board of Trustees should be permitted (during his term of office) to allow his name as an officer or a member of the Board to be used in lists endorsing candidates for public office. Naturally his right to this privilege as a private individual is not affected.

### **Public Aid**

The "chain of command and procedure" in handling problems arising in the field of public aid shall be from the county to the state society advisory committee; then the state advisory committee shall assume the responsibility of making the medical program work and cooperating with the Illinois Department of Public Aid to maintain the best type medical care for the recipients of state aid.

The fees paid by the state/federal programs to physicians shall be based upon the usual and customary fee concept.

An extensive program of education should be conducted for the recipients of public aid. This should include the intelligent handling of all monies provided.

Rehabilitation of all recipients should be of paramount concern.

### **Public Health Departments**

"Public Health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts, including contributions by voluntary health associations, medical societies and other health-oriented groups.

"Full-time modern local Health Departments adequately financed and staffed at the county or multiple county level are highly desirable and if available, would be capable of providing these services to the people throughout the state. It is of paramount importance that such departments should be established where none now exist and that county medical societies, as well as physicians, should give their wholehearted support."

### **Public Safety**

Motor vehicle operators should be licensed on the basis of the applicant's physical and mental capacity to operate such a vehicle safely.

### **Rebates**

1) "In conformity with the AMA Principles of Ethics, rebates of any nature to any member, county or regional medical society, are unethical." This statement on rebates was developed as a result of a letter regarding collection services. It read in part:

"It is our policy to remit to a participating association the sum of 10 per cent of the gross

book sales to its members in addition to 10 per cent of the gross commissions received from collections. A report and accompanying payment is submitted monthly from our office."

### **Reference Committee Appointments**

Whenever possible at least two members shall be retained on all reference committees for the following year in order to effect continuity of experience.

### **Reference Service**

Physician reference service shall be the responsibility of the county medical society. When any such request is received at the state society office or by any officer of the ISMS, it shall immediately be referred to the secretary of the county medical society involved.

### **Rehabilitation**

All physical rehabilitation activities should be prescribed by a physician and the treatment carried out under the supervision of a physician.

Medical societies should render assistance to public and private agencies regarding rehabilitation facilities to be used and in the selection of patients for these services.

Insurance carriers should be encouraged to include rehabilitation services in their contracts.

### **Relative Value**

The Relative Value Study is not a fee schedule and is to be used for information only.

No co-efficient shall be established at the state level. The data contained in the study may be used by the ISMS, its committees or by any county medical society.

The study should be revised at appropriate intervals upon the recommendation of the committee with the approval of the Board of Trustees.

Upon request, copies may be furnished third party purveyors of health care services.

### **Stationery, Use of Official**

No officer, trustee, committee chairman or staff director is to use the official stationery of the Illinois State Medical Society for personal statements of any nature. This shall pertain especially to the endorsement of any candidate for public office.

### **Surveys**

The Illinois State Medical Society endorses the principle of mass surveys and encourages the use of this method whenever it meets with the approval of the local county medical society.

Any new state program involving more than one county society should be submitted to the Board of Trustees for initial approval.

### **Veterans Administration**

It is our belief that a Veterans Administration

hospital should admit only those patients with service-connected disabilities, except in those instances where the veteran is financially unable to pay for his medical care and hospital services, as shown by a means test.

## Woman's Auxiliary

Projects in which the Auxiliary participates shall be approved by the local county medical society.

Requests for cooperation between the Auxiliary and the Illinois State Medical Society should be channeled through the Advisory Committee provided by the Board of Trustees.

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11110 S. Sawyer Ave., Chicago 60655

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30 N. Michigan, Chicago 60602

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President: Laszlo Koos  
13000 Maple Ave., Blue Island 60406  
Secy.-Tres.: John E. Driscoll  
18109 Dixie Hwy., Homewood 60430

## *Stock Yards Branch*

President: Glen A. Burckart  
11110 S. Sawyer Ave., Chicago 60655  
Secy.-Tres.: Edwin J. Lukaszewski  
1213 W. 51st St., Chicago 60609

## *West Side Branch*

President: Anna A. Marcus  
5852 W. North Ave., Chicago 60639  
Secretary: William Tansey  
414 S. Oak Park, Oak Park 60303

## CHRISTIAN COUNTY

President: W. V. Torricelli  
Kincaid 62510  
Secretary: J. W. Murphy  
301 S. Webster St., Taylorville 62568  
Members: 18—District No. 7

## CLARK COUNTY

President: Eugene P. Johnson, Casey 62410  
Secretary: Charles C. Moore, Jr.  
Martinville Clinic, Martinville 62442  
Members: 5—District No. 8

## CLAY COUNTY

President: William T. Kamp  
Flora Clinic, Flora 62839  
Secretary: Donald L. Bunnell  
Flora Clinic, Flora 62839  
Members: 8—District No. 7

## CLINTON COUNTY

President: J. A. Kirby  
401 W. Main St., Breese 62230  
Secretary: F. H. Ketterer  
289 Main St., Breese 62230  
Members: 10—District No. 7

## COLES-CUMBERLAND COUNTY

President: Otto Weiss  
212 S. 16th St., Mattoon 61938  
Secretary: Mack H. Hollowell  
35 Circle Drive, Charleston 61920  
Members: 38—District No. 8

**CRAWFORD COUNTY**

President: G. F. Schmidt, Jr.  
 408 Cross, Robinson 62454  
 Secretary: W. B. Schmidt  
 408 S. Cross, Robinson 62454  
 Members: 15—District No. 8

**DE KALB COUNTY**

President: J. J. Feeney  
 Second & Franklin, DeKalb 60115  
 Secretary: Frank E. Luedtke  
 232 Second St., De Kalb 60115  
 Members: 46—District No. 1

**DE WITT COUNTY**

President: John W. Veirs  
 219 E. Main, Clinton 61727  
 Secretary: Charles Ramey  
 215 E. Main, Clinton 61727  
 Members: 10—District No. 5

**DOUGLAS COUNTY**

President: James Taylor  
 102 N. Main, Villa Grove 61956  
 Secretary: Elmer Allen  
 120 S. Locust, Arcola 61910  
 Members: 11—District No. 8

**DU PAGE COUNTY**

President: Morgan M. Meyer  
 815 S. Main St., Lombard 60148  
 Secretary: James P. Campbell  
 322 N. Blanchard St., Wheaton 60187  
 Executive Secretary: Lillian Widmer  
 646 Roosevelt Rd., Glen Ellyn 60137  
 Members: 348—District No. 11

**EDGAR COUNTY**

President: James Acklin  
 511 N. Main St., Paris 61944  
 Secretary: J. M. Ingalls  
 Medical Center Clinic, Paris 61944  
 Members: 15—District No. 8

**EDWARDS COUNTY**

President: Paul S. Neirenborg  
 7 W. Main St., Albion 62806  
 Secretary: Andrew Krajec  
 Box 336, West Salem 62476  
 Members: 2—District No. 9

**EFFINGHAM COUNTY**

President: Nicholas Beck  
 300 Millsprings, Greenup 62428  
 Secretary: Henry Runde  
 Teutopolis 62467  
 Members: 25—District No. 7

**FAYETTE COUNTY**

President: J. H. Weiner  
 503½ Gallatin, Vandalia 62471  
 Secretary: E. A. Kuehn  
 501½ W. Gallatin, Vandalia 62471  
 Members: 11—District No. 7

**FORD COUNTY**

President: Clyde Rulison, Roberts 60962  
 Secretary: William Garrett, Sibley 61773  
 Members: 13—District No. 11

**FRANKLIN COUNTY**

President: Charles Ahlm  
 107 S. Van Buren, West Frankfort 62896  
 Secretary: M. J. Carl Allinson  
 P.O. Box 156, Benton, 62812  
 Members: 22—District No. 9

**FULTON COUNTY**

President: Jack Gibbs  
 24 Main St., Canton 61520  
 Secretary: O. M. Wood, Ipava 61441  
 Members: 24—District No. 4

**GALLATIN COUNTY**

President: Joe Bryant, Ridgway 62979  
 Secretary: John Doyle, Ridgway 62979  
 Members: 3—District No. 9

**GREENE COUNTY**

President: Jude A. Castleton  
 419 N. Main St., Carrollton 62016  
 Secretary: A. K. Baldwin  
 229 N. Fifth St., Carrollton 62016  
 Members: 10—District No. 6

**HANCOCK COUNTY**

President: Christian W. Bruehsel  
 Warsaw Clinic, Warsaw 62379  
 Secretary: Ilse Erika Bruehsel,  
 Warsaw Clinic, Warsaw 62379  
 Members: 9—District No. 4

**HENDERSON COUNTY**

President: S. S. Lindo, Jr., Biggsville 61418  
 Secretary: Harold L. Bock, Box 338,  
 Stronghurst 61480  
 Members: 2—District No. 4

**HENRY-STARK COUNTY**

President: Fred V. Colby  
 119 W. Exchange, Geneseo 61254  
 Secretary: Roberto S. Puentes  
 100 E. Main St., Geneseo 61254  
 Members: 32—District No. 4

**IROQUOIS COUNTY**

President: Ryland A. Buckner  
 219 N. Central Ave., Gilman 60938  
 Secretary: N. Dean Hungness  
 100 First St., Box 126, Sheldon 60966  
 Members: 18—District No. 11

**JACKSON COUNTY**

President: John P. Goff  
 404 W. Main St., Carbondale 62901  
 Secretary: Homer H. Hanson  
 404 W. Main, Carbondale 62901  
 Members: 48—District No. 10

**JASPER COUNTY**

President: Don Hartrich  
 Box 192, Newton 62448  
 Secretary: C. O. Absher, Newton 62448  
 Members: 3—District No. 8

**JEFFERSON-HAMILTON COUNTY**

President: C. K. Wells  
 117 N. 10th St., Mt. Vernon 62864  
 Secretary: Robert J. Dancy  
 605 N. 18th St., Mt. Vernon 62864  
 Members: 24—District No. 9



**JERSEY-CALHOUN COUNTY**

President: F. Gorecki  
 205 N. State St., Jerseyville 62052  
 Secretary: Clyde L. Wieland  
 300 S. Washington, Jerseyville 62052  
 Members: 9—District No. 6

**JO DAVIESS COUNTY**

President: David Hockman  
 300 Summit St., Galena 61036  
 Secretary: William G. Gillies  
 300 Summit St., Galena 61036  
 Members: 8—District No. 1

**KANE COUNTY**

President: Robert G. Stone  
 860 Summit St., Elgin 60120  
 Secretary: Julius S. Newman  
 157 S. Lincoln Ave., Aurora 60505  
 Corresponding Secretary: Elsa Carlson  
 17 N. Sixth St., Geneva 60134  
 Members: 235—District No. 1

**KANKAKEE COUNTY**

President: R. Schuller  
 Herscher Medical Bldg., Herscher 60941  
 Executive Secretary: Mrs. Julia P. Schulz  
 450 Kennedy Dr., Kankakee 60901  
 Members: 87—District No. 11

**KENDALL COUNTY**

President: Stefan Wojtowycz  
 8 E. Main, Plano 60545  
 Secretary: Victor H. Smith  
 Johnson St., Newark 60541  
 Members: 78—District No. 11

**KNOX COUNTY**

President: J. K. Erffmeyer  
 369 N. Kellogg, Galesburg 61401  
 Secretary: K. K. Kleinkauf  
 311 E. Main St., Galesburg 61401  
 Members: 61—District No. 4

**LAKE COUNTY**

President: Jerome Waldman  
 1616 Grand Ave., Waukegan 60085  
 Secretary: John Andrews  
 1616 Grand Ave., Waukegan 60085  
 Executive Secretary: Mrs. Julia P. Schulz  
 P.O. Box 148, Gurnee 60031  
 Members: 248—District No. 1

**LA SALLE COUNTY**

President: Jerome Sickley  
 206 Marquette, LaSalle 61301  
 Secretary: Allan L. Goslin  
 1005 N. Park St., Streator 61364  
 Members: 102—District No. 2

**LAWRENCE COUNTY**

President: Gilbert Miller  
 Medical Center, North Main St.,  
 Bridgeport 62417  
 Secretary: Charles G. Stoll  
 802 Jefferson St., Lawrenceville, 62439  
 Executive Secretary: Ruth E. Gariepy  
 Lawrence City Mem. Hospital, Lawrenceville  
 62439  
 Members: 9—District No. 8

**LEE COUNTY**

President: R. Silve  
 120 W. South St., Franklin Grove 61031  
 Secretary: George Silvest  
 114 E. Everett Ave., Dixon 61021  
 Members: 19—District No. 2

**LIVINGSTON COUNTY**

President: Glenn E. Hudgens  
 115 E. Walnut St., Fairbury 61739  
 Secretary: Karl T. Deterding  
 Bank of Pontiac Bldg., Pontiac 61764  
 Members: 28—District No. 2

**LOGAN COUNTY**

President: Gilbert Blaum  
 514 Pine, Lincoln 62656  
 Secretary: Glen E. Tomlinson  
 4 Lincoln Prof. Park, Lincoln 62656  
 Members: 22—District No. 5

**MACON COUNTY**

President: Thomas W. Samuels, Jr.  
 348 Prairie St., Decatur 62522  
 Secretary: Paul Reeder  
 2113 N. Edward, Decatur 62526  
 Executive Secretary: Mary J. Bretz  
 1800 E. Lake Shore Dr., Decatur 62521  
 Members: 132—District No. 7

**MACOUPIN COUNTY**

President: Frank B. Warner  
 Box 248, Mt. Olive 62069  
 Secretary: Robert H. Rutherford  
 224 E. Main St., Carlinville 62626  
 Members: 24—District No. 6

**MADISON COUNTY**

President: Louis Ventura  
 Madison County Sanatorium, Edwardsville  
 62025  
 Secretary: Leo R. Green  
 1114 Milton Rd., Alton 62002  
 Members: 124—District No. 6

**MARION COUNTY**

President: Maurice T. Horsman  
 624 W. Main St., Salem 62881  
 Secretary: Walter Plassman  
 Box 552, Centralia 62801  
 Members: 29—District No. 7

**MASON COUNTY**

President: Dario Landazuri  
 125 N. Orange St., Havana 62644  
 Secretary: Henry W. Maxfield, Mason City 62664  
 Members: 8—District No. 5

**MASSAC COUNTY**

President: G. Green  
 600 Ferry St., Metropolis 62960  
 Secretary: Virgil O. Decker  
 105½ E. 5th St., Metropolis 62960  
 Members: 8—District No. 9

**MCDONOUGH COUNTY**

President: W. P. Standard  
 301 E. Jefferson St., Macomb 61455  
 Secretary: J. L. Symmonds  
 301 E. Jefferson St., Macomb 61455  
 Members: 21—District No. 4

**McHENRY COUNTY**

President: Peter Griesbach  
1110 N. Green St., McHenry 60050  
Secretary: V. B. Petralia  
210 Northwest Highway, Fox River 60021  
Executive Secretary: Evelyn Rosulek  
308 Kimball Ave., Woodstock 60098  
Members: 60—District No. 1

**McLEAN COUNTY**

President: Homer Lyman  
429 N. Main, Bloomington 61701  
Secretary: A. E. Livingston  
429 N. Main, Bloomington 61701  
Executive Secretary: David W. Meister  
429 N. Main St., Bloomington 61701  
Members: 81—District No. 5

**MENARD COUNTY**

President: Robert Schafer  
116 N. 5th St., Petersburg 62675  
Secretary: H. K. Moulton  
119 N. 7th St., Petersburg 62675  
Members: 4—District No. 5

**MERCER COUNTY**

President: R. N. Svendsen  
109 S. 7th St., Aledo 61231  
Secretary: James W. Hastings  
209 S. College Ave., Aledo 61231  
Members: 6—District No. 4

**MONROE COUNTY**

President: Russell W. Jost  
107 E. 4th St., Waterloo 62298  
Secretary: Joseph Werth  
Box, 127, Waterloo 62298  
Members: 8—District No. 10

**MONTGOMERY COUNTY**

President: Rudolf Sommer  
515 N. Monroe St., Litchfield 62056  
Secretary: Vincent J. Parlente  
302 S. Main St., Hillsboro 62049  
Members: 16—District No. 5

**MORGAN COUNTY**

President: Joseph J. Kozma  
1440 W. Walnut, Jacksonville 62650  
Secretary: Robert H. Kooiker  
801 Lincoln Ave., Jacksonville 62650  
Members: 37—District No. 6

**MOULTRIE COUNTY**

President: Eugene Boros  
Bethany 61914  
Secretary: H. E. Kendall  
112 E. Harrison, Sullivan 61951  
Members: 5—District No. 7

**OGLE COUNTY**

President: Warren Duane Dodd  
Byron Medical Clinics, Byron 61010  
Secretary: Russell Zack  
515 Lincoln Hwy., Rochelle 61068  
Members: 21—District No. 1

**PEORIA COUNTY**

President: Paul R. Dirkse  
427 First Nat'l. Bank Bldg., Peoria 61602

Secretary: Dean R. Bordeaux  
427 First Natl. Bank Bldg., Peoria 61602  
Executive Secretary: David W. Meister  
427 First Nat'l. Bank Bldg., Peoria 61602  
Members: 232—District No. 4

**PERRY COUNTY**

President: George D. Mohr  
206 N. Main, Pickneyville 62274  
Secretary: James B. Stotlar  
15 N. Walnut St., Pickneyville 62274  
Members: 17—District No. 10

**PIATT COUNTY**

President: George Green  
340 N. State St., Monticello 61856  
Secretary: Joseph Allman  
121 N. State St., Monticello 61856  
Members: 6—District No. 7

**PIKE COUNTY**

President: Gene Goodman  
Box 177, Pleasant Hill 62366  
Secretary: Thomas C. Bunting  
321 W. Washington, Pittsfield 62363  
Members: 9—District No. 6

**PULASKI COUNTY**

President: A. L. Robinson  
104A North Front St., Mounds 62964  
Secretary: Marvin F. Powers  
107A South Oak St., Mounds 62964  
Members: 2—District No. 10

**RANDOLPH COUNTY**

President: R. G. Benson  
101 N. Market St., Sparta 62286  
Secretary: C. S. Schlageter  
101 N. Market, Sparta 62286  
Members: 18—District No. 10

**RICHLAND COUNTY**

President: C. Harrison  
600 E. Main St., Olney 62450  
Secretary: T. Martin  
Weber Medical Clinic, Olney 62450  
Members: 21—District No. 8

**ROCK ISLAND COUNTY**

President: David W. Murrell  
532 19th Ave., Moline 61265  
Secretary: Robert Wells  
1760 44th St., Rock Island 61201  
Executive Secretary: James A. Koch  
612 Kahl Building, Davenport, Iowa 52801  
Members: 141—District No. 4

**ST. CLAIR COUNTY**

President: Kilian Fritsch  
4825 W. Main St., Belleville 62223  
Secretary: Charles Frazer  
4825 W. Main St., Belleville 62223  
Executive Director: Ed Belz  
4825 W. Main St., Belleville 62223  
Members: 177—District No. 10

**SALINE-POPE-HARDIN COUNTY**

President J. Dale Cavaness  
1405 Locust St., Eldorado 62930  
Secretary: William R. Durham  
203 N. Vine St., Harrisburg 62946  
Members: 23—District No. 9



**SANGAMON COUNTY**

President: F. Paul LaFata  
 2412 S. Glenwood, Springfield 62704  
 Secretary: David B. Lewis  
 Memorial Hospital, Springfield 62701  
 Executive Secretary: L. R. Brosi  
 2100 Lindsay Rd., Springfield 62704  
 Members: 196—District No. 5

**SCHUYLER COUNTY**

President: R. R. Dohner  
 103 W. Washington, Rushville 62681  
 Secretary: Henry C. Zingher  
 Rushville Clinic, Rushville 62681  
 Members: 3—District No. 4

**SHELBY COUNTY**

President: R. Larsen  
 Shelbyville 62565  
 Secretary: Smith D. Taylor  
 520 Penns. Ave., Windsor 61957  
 Members: 8—District No. 7

**STEPHENSON COUNTY**

President: D. J. Chang  
 324 Galena Ave., Freeport 61032  
 Secretary: F. C. Tucker  
 420 S. Harlem Ave., Freeport 61032  
 Members: 38—District No. 1

**TAZEVELL COUNTY**

President: Arnold H. Claycomb  
 427 First Nat'l. Bank Bldg., Peoria 61602  
 Secretary: Robert M. Wright  
 427 First Nat'l Bank Bldg., Peoria 61602  
 Executive Secretary: David W. Meister  
 427 First Nat'l. Bank Bldg., Peoria 61602  
 Members: 45—District No. 5

**UNION COUNTY**

President: William H. Whiting  
 Box 410, Anna 62906  
 Secretary: William H. Whiting  
 Box 410, Anna 62906  
 Members: 7—District No. 10

**VERMILION COUNTY**

President: Donald D. Spicer  
 733 N. Logan Ave., Danville 61832  
 Secretary: L. W. Tanner  
 7 N. Virginia, Danville 61832  
 Members: 84—District No. 8

**WABASH COUNTY**

President: R. A. Richey, Grayville 62844  
 Secretary: C. L. Johns  
 114 W. Fifth, Mt. Carmel 62863  
 Members: 8—District No. 9

**WARREN COUNTY**

President: Joseph Simmons, Kirkwood 61447  
 Secretary: Glen Chamberlin  
 219 E. Euclid, Monmouth 61462  
 Members: 11—District No. 4

**WASHINGTON COUNTY**

President: Charles W. Longwell  
 111 S. Washington, Nashville 62263  
 Secretary: Jerry L. Beguelin  
 Box 197, Irvington 62848  
 Members: 3—District No. 10

**WAYNE COUNTY**

President: Gilbert T. Ransom  
 209 S. E. Third St., Fairfield 62837  
 Secretary: Arthur R. Marks  
 101 E. Center, Fairfield 62837  
 Members: 6—District No. 9

**WHITE COUNTY**

President: J. A. Stricklin  
 West Main St., Carmi 62821  
 Secretary: William H. Courtneage  
 Carmi Medical Center, Carmi 62821  
 Members: 7—District No. 9

**WHITESIDE COUNTY**

President: Saul Parks  
 407 W. 13th St., Sterling 61081  
 Secretary: Erwin Roubiecek  
 24 E. Third St., Sterling 61081  
 Members: 41—District No. 2

**WILL-GRUNDY COUNTY**

President: Barry S. Seng  
 219 Bedford Rd., Morris 60450  
 Secretary: Albin B. Brixey  
 120 Scott St., Joliet 60431  
 Executive Secretary: Don C. Kline  
 58 N. Chicago St., Joliet 60435  
 Members: 191—District No. 11

**WILLIAMSON COUNTY**

President: James Felts  
 517 Bainbridge Rd., Marion 62959  
 Secretary: Herbert V. Fine  
 110 N. Division, Carterville 62918  
 Members: 29—District No. 9

**WINNEBAGO COUNTY**

President: E. A. Schilling  
 995 N. Main St., Rockford 61103  
 Secretary: D. P. Feeney  
 2300 N. Rockton Ave., Rockford 61103  
 Executive Administrator: Donald A. Westbrook  
 310 N. Wyman St., Rockford 61101  
 Members: 261—District No. 1

**WOODFORD COUNTY**

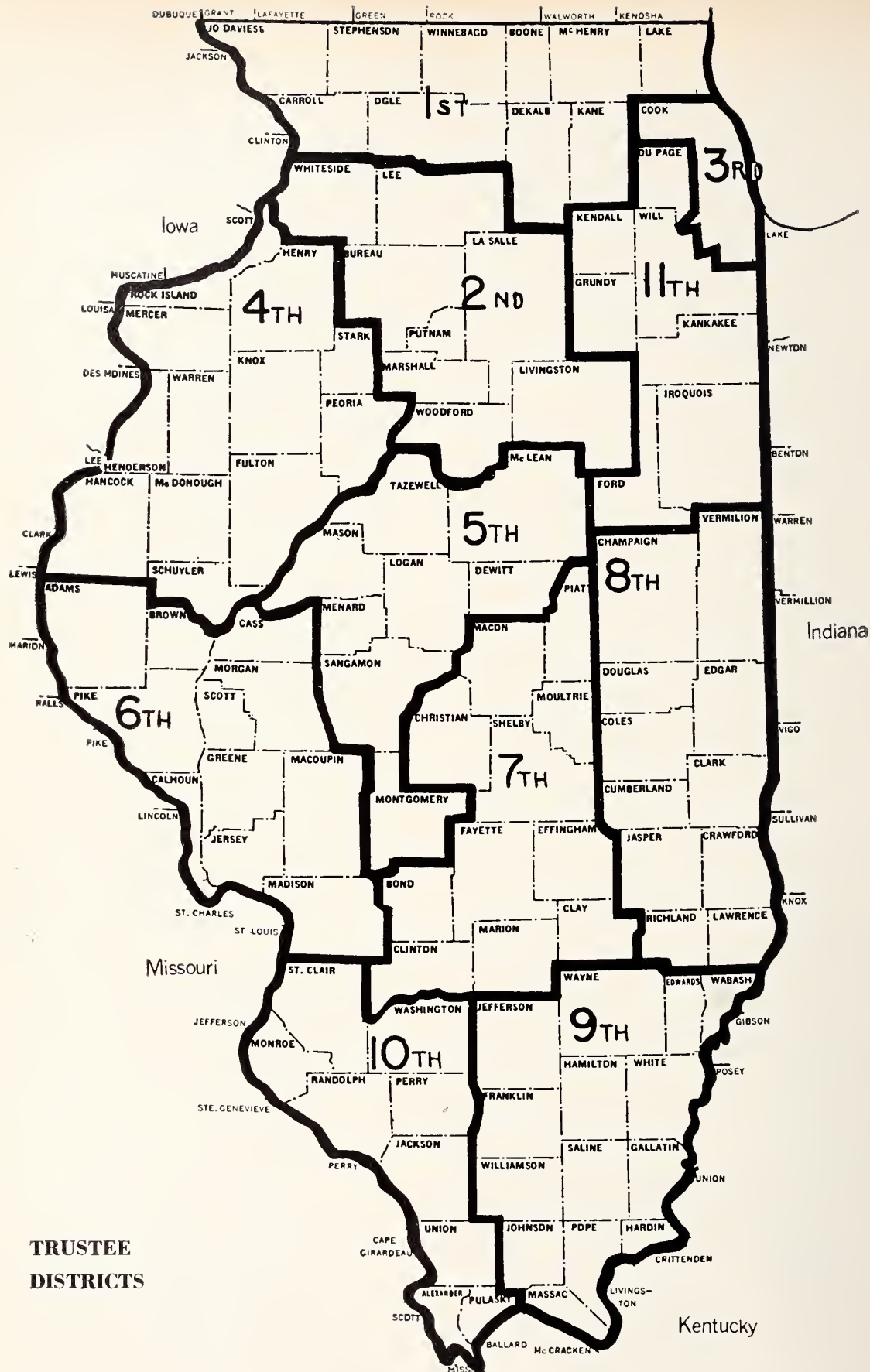
President: R. P. Lykkebak  
 399 W. Front St., El Paso 61738  
 Secretary: James Riley  
 109 S. Major St., Eureka 61530  
 Members: 9—District No. 2

**NO ORGANIZED****COUNTY SOCIETY**

Brown  
 Johnson  
 Marshall  
 Putnam  
 Scott

**JOINT COUNTY SOCIETIES**

Coles-Cumberland  
 Henry-Stark  
 Jefferson-Hamilton  
 Jersey-Calhoun  
 Saline-Pope-Hardin  
 Will-Grundy



**TRUSTEE  
DISTRICTS**



## TRUSTEE DISTRICT COMMITTEES

### First District

Joseph L. Bordenave, Geneva, *Trustee*  
Counties of Boone, Carroll, DeKalb, Jo Daviess,  
Kane, Lake, McHenry, Ogle, Stephenson, Winne-  
bago

ETHICAL RELATIONS COMMITTEE TERM EXPIRES  
John H. Steinkamp, Belvidere, *Chairman* .....1972  
Gerald Liesen, St. Charles .....1970  
John W. Ovitz Jr., Sycamore .....1971  
E. J. McKinney, Rockford .....1972

GRIEVANCE COMMITTEE  
Russell Zack, Rochelle, *Chairman* .....1970  
R. Gregory Green, Rockford .....1972  
M. Mijanovich, Marengo .....1971  
Walter J. Reedy, Waukegan .....1972

PREPAYMENT PLANS & ORGANIZATIONS  
Kenneth L. Morris, Stockton, *Chairman* ....1971  
Jerald A. Bowman, Rockford .....1971  
John E. Madden, Freeport .....1970  
Rodney Nelson, Geneva .....1972  
Erwin A. Schilling, Rockford .....1972  
R. E. Whitsitt, Rockford .....1972  
Delbert O. Williams, Jr., Stockton .....1971

### Second District

William A. McNichols, Jr., Dixon, *Trustee*  
Counties of Bureau, LaSalle, Lee, Livingston,  
Marshall, Putnam, Whiteside, Woodford

ETHICAL RELATIONS COMMITTEE  
K. Dexter Nelson, Princeton, *Chairman* .....1971  
Ralph Bailey, Ottawa .....1972  
Tim Sullivan, Sterling .....1970

GRIEVANCE COMMITTEE  
K. M. Nelson, Princeton, *Chairman* .....1972  
Francis J. Brennan, Utica .....1970  
Edward Murphy, Dixon .....1971  
Philip Terry, Kewanee .....1970

PREPAYMENT PLANS & ORGANIZATIONS  
M. D. Burnstine, Sterling, *Chairman* .....1970  
Wm. Ehling, Streator .....1971  
Joseph Phifer, Eureka .....1972

### Third District

William E. Adams, Chicago, *Trustee*  
James B. Hartney, Oak Park, *Trustee*  
Frank J. Jirka, Jr. River Forest, *Trustee*  
Fredric D. Lake, Evanston, *Trustee*  
William M. Lees, Lincolnwood, *Trustee*  
Warren W. Young, Chicago, *Trustee*

*No district committees are appointed.*

### Fourth District

Paul P. Youngberg, Moline, *Trustee*  
Counties of Fulton, Hancock, Henderson, Henry,  
Knox, McDonough, Mercer, Peoria, Rock Is-  
land, Schuyler, Stark, Warren

ETHICAL RELATIONS COMMITTEE TERM EXPIRES  
Richard Icenogle, Roseville, *Chairman* .....1971  
John Bowman, Abingdon .....1970  
Loren Helfrich, Moline .....1972

GRIEVANCE COMMITTEE  
Russell Jensen, Monmouth, *Chairman* .....1970  
F. A. Christensen, Peoria .....1972  
Wm. G. Neilson, Kewanee .....1972

PREPAYMENT PLANS & ORGANIZATIONS  
William O. McQuiston, Peoria, *Chairman* ....1972  
James C. Parsons, Geneseo .....1970  
Donald Dexter, Macomb .....1971

### Fifth District

Darrell H. Trumpe, Springfield, *Trustee*  
Counties of DeWitt, Logan, McLean, Mason,  
Menard, Montgomery, Sangamon, Tazewell

ETHICAL RELATIONS COMMITTEE  
Arthur Conklin, Bloomington, *Chairman* ....1970  
William W. Curtis, Springfield .....1971  
Jack Means, Mason City .....1972

GRIEVANCE COMMITTEE  
Robert Schaefer, Petersburg, *Chairman* .....1972  
James Borgerson, Mt. Pulaski .....1971

PREPAYMENT PLANS & ORGANIZATIONS  
J. G. Meyer, Jr., Springfield, *Chairman* .....1972  
Robert B. Perry, Lincoln .....1970  
Robert Price, Bloomington .....1971

## Sixth District

Mather Pfeiffenberger, Alton, *Trustee*  
Counties of Adams, Brown, Calhoun, Cass,  
Green, Jersey, Macoupin, Madison, Morgan,  
Pike, Scott

ETHICAL RELATIONS COMMITTEE TERM EXPIRES  
W. W. Bowers, Granite City, *Chairman* .....1970  
Joseph J. Grandone, Gillespie .....1971  
Edward K. DuVivier, Alton .....1971  
Bernard Baalman, Hardin .....1972

GRIEVANCE COMMITTEE  
Richard Cooper, Quincy, *Chairman* .....1971  
Bruno DeSulis, Beardstown .....1971  
Robert R. Hartman, Jacksonville .....1972  
Robert C. Murphy, Quincy .....1970

PREPAYMENT PLANS & ORGANIZATIONS  
E. C. Bone, Jacksonville, *Chairman* .....1970  
James Reid, Greenfield .....1971  
Jude A. Caselton, Carrollton .....1972  
Frank B. Norbury, Jacksonville .....1972  
Meyer Shulman, Pittsfield .....1971

## Eighth District

William H. Schowengerdt, Champaign, *Trustee*  
Counties of Champaign, Clark, Coles, Crawford,  
Cumberland, Douglas, Edgar, Jasper, Lawrence,  
Richland, Vermilion

ETHICAL RELATIONS COMMITTEE  
Mack W. Hollowell, Charleston, *Chairman* .....1971  
James H. Pass, Olney .....1972  
Alan M. Taylor, Danville .....1970

GRIEVANCE COMMITTEE  
A. R. Brandenberger, Danville, *Chairman* .....1971  
Eugene Johnson, Casey .....1972  
Gordon Sprague, Paris .....1970

PREPAYMENT PLANS & ORGANIZATIONS  
James W. Landis, Olney, *Chairman* .....1971  
E. A. Kendall, Mattoon .....1970  
George T. Mitchell, Marshall .....1972

## Tenth District

Willard C. Scrivner, East St. Louis, *Trustee*  
Counties of Alexander, Jackson, Monroe, Perry,  
Pulaski, Randolph, St. Clair, Union,  
Washington

ETHICAL RELATIONS COMMITTEE  
A. L. Robinson, Mounds, *Chairman* .....1970  
Harold McCann, East St. Louis .....1971  
William Borgsmiller, Murphysboro .....1972

PREPAYMENT PLANS & ORGANIZATIONS  
Joseph A. Petrazio, Murphysboro, *Chairman* .....1970  
R. W. Jost, Waterloo, .....1972  
R. E. Schettler, Red Bud .....1971

## Seventh District

Arthur F. Goodyear, Decatur, *Trustee*  
Counties of Bond, Christian, Clay, Clinton,  
Effingham, Fayette, Macon, Marion, Moultrie,  
Piatt, Shelby

ETHICAL RELATIONS COMMITTEE TERM EXPIRES  
Max Hirschfelder, Centralia, *Chairman* .....1971  
E. H. Rames, Vandalia .....1972  
Carl L. Sandburg, Decatur .....1970

GRIEVANCE COMMITTEE  
Karl D. Venters, Centralia, *Chairman* .....1970  
Boyd McCracken, Greenville .....1971  
William Sargent, Effingham .....1972

PREPAYMENT PLANS & ORGANIZATIONS  
Clarence Glenn, Decatur, *Chairman* .....1972  
Richard Larson, Shelbyville .....1971  
Stanley W. Moore, Vandalia .....1970

## Ninth District

Charles K. Wells, Mt. Vernon, *Trustee*  
Counties of Edwards, Franklin, Gallatin, Hamil-  
ton, Hardin, Jefferson, Johnson, Massac, Pope,  
Saline, Wabash, Wayne, White, Williamson

ETHICAL RELATIONS COMMITTEE  
Donald Mitchell, McLeansboro, *Chairman* .....1970  
Philip Boren, Carmi .....1971  
Warren D. Tuttle, Harrisburg .....1972

GRIEVANCE COMMITTEE  
C. J. Jannings, III, Fairfield, *Chairman* .....1970  
Herbert Fine, Cartersville .....1972  
John Duffey, Rosiclare .....1971

PREPAYMENT PLANS & ORGANIZATIONS  
Denton Farrell, Eldorado, *Chairman* .....1971  
H. L. Lewis, Benton .....1970  
A. Watson Miller, Herrin .....1972



## Eleventh District

Joseph R. O'Donnell, Glen Ellyn, *Trustee*  
Counties of DuPage, Ford, Grundy, Iroquois,  
Kankakee, Kendall, Will

### ETHICAL RELATIONS COMMITTEE

James Ryan, Kankakee, *Chairman* .....1972  
John Bowden, Joilet .....1971  
Lawrence D. Lee, Manhattan .....1970

## DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Elected May 24, 1967

(to serve from Jan. 1, 1968 to Dec. 31, 1969)

H. KENNETH SCATLIFF  
1415 Greenleaf Ave., Chicago  
WALTER C. BORNEMEIER  
4665 Peterson Ave., Chicago  
FRANK H. FOWLER  
6356 Diversey Ave., Chicago  
ARTHUR F. GOODYEAR  
142 E. Prairie Ave., Decatur  
HARLAN ENGLISH  
909 N. Logan Ave., Danville  
EDWARD W. CANNADY  
4601 State St., East St. Louis

Elected May 21, 1968

(To serve from Jan. 1, 1969 to Dec. 31, 1970)

MAURICE M. HOELTGEN  
1836 W. 87th St., Chicago 60620  
LEO P. A. SWEENEY  
10400 S. Western Ave., Chicago 60643  
H. CLOSE HESSELTINE  
5708 S. Dorchester Ave., Chicago 60637  
WILLIAM K. FORD  
303 N. Main St., Rockford 61101  
JACOB E. REISCH  
1129 S. 2nd St., Springfield 62704

Elected May 21, 1969

(To serve from Jan. 1, 1970 to Dec. 31, 1971)

Edward A. Piszczek  
Walter C. Bornemeier\*  
Philip G. Thomsen  
Theodore Grevas  
Harlan English  
Edward W. Cannady  
*Honorary Delegates*  
Edwin S. Hamilton,  
151 N. Schuyler St., Kankakee  
Burtis E. Montgomery,  
37 S. Main St. Harrisburg  
George F. Lull,  
2440 Lakeview, Chicago

### GRIEVANCE COMMITTEE

William C. Perkins, West Chicago, *Chairman* 1970  
Guy Pandola, Joliet .....1972  
Victor Smith, Newark .....1971

### PREPAYMENT PLANS & ORGANIZATIONS

James Campbell, Wheaton, *Chairman* .....1972  
James E. Dailey, Watseka .....1972  
James Lambert, Joilet .....1970  
Julius Schweitzer, Hinsdale .....1971

## ALTERNATE DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Elected May 24, 1967

(To serve from Jan. 1, 1968 to Dec. 31, 1969)

Harold A. Sofield, 715 Lake St., Oak Park 60301  
George C. Turner, 6627 Ponchartrain Ave.,  
Chicago 60646  
Edward A. Piszczek, 6410 N. Leona Ave.,  
Chicago 60646  
Newton DuPuy, 1842 Grove Ave., Quincy 62301  
Joseph R. Mallory, Link Clinic, Mattoon 61938  
Carl E. Clark, Sycamore 60178

Elected May 21, 1968

(To serve from Jan. 1, 1969 to Dec. 31, 1970)

Theodore R. VanDellen, 435 N. Michigan Ave.,  
Chicago 60611  
Allison L. Burdick, Sr., 5906 W. North Ave.,  
Chicago 60639  
Arkell M. Vaughn, 9012 S. Leavitt St., Chicago  
60620  
Paul A. Dailey, 620 N. Main St., Carrollton 62016  
Jack Gibbs, Coleman Clinic, Canton 61520

Elected May 21, 1969

(To serve from Jan. 1, 1970 to Dec. 31, 1971)

Harold A. Sofield  
George C. Turner  
Francis W. Young  
Morgan M. Meyer  
Carl E. Clark  
Joseph R. Mallory

\*President Elect, A.M.A.

Elected July, 1969.

# Councils of the Illinois State Medical Society

Committees of the Illinois State Medical Society are appointed by the Chairman of the Board of Trustees subject to approval of the Board of Trustees, and are assigned to one of eight councils. The councils are similarly appointed and are composed of committee chairmen and such other members as felt necessary to accomplish the purposes of the council. Some committees are composed of members of the Board of Trustees and are designated Board Committees. Two committees report directly to the board and are not assigned to a council. Task Forces are established to address a particular problem or concern which crosses areas of responsibility of the several councils. The task forces report directly to the board, as do representatives to various other agencies.

## COUNCIL ON ECONOMICS AND GOVERNMENT HEALTH PROGRAMS

Fred Z. White, *Chairman*

732 N. Second St., Chillicothe 61523

Charles E. Baldree, Jr.

26 E. Washington St., Belleville 62220

William E. Barnes

1616 Grand, Waukegan 60085

Eli Borkon (Advisory to Div. of Vocational Rehabilitation)

Box 1030, Carbondale 62901

Ralph Dolkart

707 Fairbanks Ct., Chicago 60611

Rex O. McMorris (Advisory to IDPA)

619 N. E. Glen Oak Ave., Peoria 61603

Robert C. Muehrcke (Drugs and Therapeutics)

518 N. Austin Blvd., Oak Park 60302

Fred A. Tworoger

4753 Broadway, Chicago 60640

Theodore Wachowski (Prepayment Plans and Organizations)

310 Ellis Avenue, Wheaton 60187

CONSULTANT: George Shropshire

1525 E. 53rd St., Chicago 60615

Joseph L. Bordenave

1665 South Street, Geneva 60134

STAFF: Joseph Lotharius

### Responsibilities and Purposes:

The Council on Economics and Government Health Programs shall:

1) Initiate, explore and bring to the attention of the Board of Trustees suggested policies and philosophies relating to medical service in Illinois;

2) Advise the staff in socio-economic issues and further the health and welfare of the public by seeking continuous improvement of medical services in Illinois;

3) Provide a channel of communication between ISMS and the federal health agencies, the health insurance industry, Blue Cross-Blue Shield Plans and similar organizations in matters of mutual concern.

4) Advise the Illinois Department of Public Aid, the Division of Vocational Rehabilitation and other state health agencies on matters pertaining to fees and the quality of medical services;

5) Establish and implement peer review programs covering private, as well as government health programs.

### COMMITTEES:

Prepayment Plans and Organizations

Advisory Committee to Ill. Department of Public Aid

Sub-committee on Drugs and Therapeutics  
Advisory Committee to Dept. of Vocational Rehabilitation

## COUNCIL ON EDUCATION AND MANPOWER

Jack Gibbs, *Chairman*, 24-26 Main St., Canton 61520

Herschel L. Browns, 4600 N. Ravenswood Ave., Chicago 60640 (Continuing Education)

Robert T. Fox, 2136 Robin Crest Ln., Glenview 60025 (Scientific Assembly)

Norman Frank, 421 Park Ave., Clarendon Hills 60514 (Adv. Comm. to SAMA)

Morgan M. Meyer, 815 S. Main St., Lombard 60148

Herman J. Nebel, 629 Vogel Ave., East St. Louis 62205

R. Charles Oldfield, Jr., 40 S. Clay, Hinsdale 60521

James M. Schless, 3249 S. Oak Park Ave., Berwyn 60402

Donald Stehr, 102 E. Market, Havana 62644 (Student Loan Fund)

### CONSULTANTS:

Wm. A. McNichols, Jr.

101 W. 1st St., Dixon 61021

Joseph R. O'Donnell

444 Park, Glen Ellyn 60137

Wm M. Lees

6518 N. Nokomis, Lincolnwood 60646

Philip G. Thomsen

13826 Lincoln Ave., Dolton 60419

*Representatives of Medical School Deans:*

James Shaffer

Chicago Medical School,

2020 W. Odgen Ave., Chicago 60612



Edward S. Petersen

Northwestern University

303 E. Chicago Ave., Chicago 60611

Richard M. Magraw

University of Illinois Medical Center

Box 6998, Chicago 60680

Richard Landau

University of Chicago Pritzker School of

Medicine, 950 E. 59th St., Chicago 60637

William B. Rich

Stritch School of Medicine, Loyola University

2160 S. 1st Ave., Maywood 60153

STAFF: Perry L. Smithers

### Responsibilities and Purposes

The Council on Education and Manpower shall (1) study and evaluate all phases of medical education including the development of programs approved by the House of Delegates for the provision of a continuing supply of well-qualified physicians; (2) study and evaluate education relating to the health professions and services important to medicine, including the development of programs approved by the House of Delegates for the provision of a continuing supply of well-

qualified personnel in these fields; (3) carry to the deans of the medical schools recommendations from the viewpoint of the practicing physician; (4) study, evaluate and criticize the post-graduate programs of ISMS and other organizations; (5) be available to advise and cooperate with the Department of Registration and Education of the State of Illinois; (6) serve as liaison between ISMS and the Student American Medical Association; (7) administer the Student Loan Fund program which is operated jointly by ISMS and the Illinois Agricultural Association; and (8) organize, coordinate and administer the scientific sessions of the ISMS subject to the regulations outlined in the Bylaws, especially those in Chapter II, Annual Convention, Section 3, Scientific Meetings.

### COMMITTEES:

Continuing Education

Scientific Assembly

Student Loan Fund

Advisory to SAMA

## COUNCIL ON ENVIRONMENTAL AND COMMUNITY HEALTH

Edward A. Piszczek, *Chairman*, 6410 N. Leona, Chicago 60646

Howard C. Burkhead, *Co-Chairman*, 2650 Ridge Ave., Evanston 60201

James P. Campbell, 322 N. Blanchard St. Wheaton 60187 (Public Safety)

Eugene F. Diamond, 11055 S. St. Louis, Chicago 60655 (Nutrition)

Clifton Hall, 504 State Office Bldg., Springfield 62706

Robert R. Hartman, 1515A W. Walnut St., Jacksonville 62650 (Maternal Welfare)

John S. Hyde, 715 Lake St., Oak Park 60301

Ralph H. Kunstadter, 664 N. Michigan Ave., Chicago 60611 (Child Health)

David F. Lowen, 400 W. Hays, Decatur 62526

Robert J. Maganini, 727 W. Hickory, Hinsdale 60521

Arthur E. Sulek, 2710 Bradley Rd., Rockford 61107

### CONSULTANTS:

Darrell H. Trumpe, St. Johns Sanatorium, Springfield 62707

Willard C. Scrivner

4601 State St., East St. Louis 62205

Warren W. Young

10816 Parnell, Chicago 60628

STAFF: Perry L. Smithers

### Responsibilities and Purposes

The Council on Environmental & Community Health shall cooperate with the Illinois Depart-

ment of Public Health in certain specific areas. Its responsibilities shall include the maintenance, protection and improvement of the health of the people of Illinois through organized community efforts.

It shall serve as a source of information on chronic illness and communicable diseases and cooperate with institutions and voluntary health agencies in disseminating such information.

It is responsible for medicine's interest in the relationship of man to his surroundings, particularly air, water and soil pollution; health problems related to population growth, urbanization and technological development bearing on the ecology of man.

The council also shall be concerned with diseases and problems associated with occupational and industrial health, cooperate with the Council on Occupational Health of AMA, Industrial Medical Association and similar state agencies and to recommend to the State of Illinois Workman's Compensation Board medical procedures designed to assist the board in the evaluation of claims.

### COMMITTEES:

Public Safety

Child Health

Maternal Welfare

Nutrition

Ad Hoc Radiation

## COUNCIL ON LEGISLATION AND PUBLIC AFFAIRS

V. P. Siegel, *Chairman*, 4601 State St., East St.  
Louis 62205  
Richard Allyn, 709 Myers Building, Springfield  
62701  
Alfred J. Faber, 2110 Swainwood Dr., Glenview  
60025  
Theodore Grevas, (Public Affairs) 1800 Third  
Ave., Rock Island 61201  
Frank J. Kresca, (Eye) 208 W. Green, Cham-  
paign 61822  
Eugene J. Scherba, 13826 Lincoln Ave., Dolton  
60419  
Thomas P. deGraffenried, 1208 Sunnymeade, De-  
Kalb 60115  
Warren Tuttle 203 North Vine St., Harrisburg  
62946

### CONSULTANTS:

H. Close Hesseltine, 5807 S. Dorchester  
Avenue, Chicago 60637  
Harold A. Sofield, 715 Lake St., Oak Park  
60301  
Philip G. Thomsen  
13826 Lincoln Ave., Dolton 60419  
William M. Lees, 6518 N. Nokomis, Lin-  
colnwood 60646

### AUXILIARY REPRESENTATIVE:

Mrs. Alan Taylor, 1607 N. Vermilion,  
Danville 61832

STAFF: Arthur W. Seeds

### Responsibilities and Purposes

The Council on Legislation and Public Affairs shall:

1. Keep the Society and its members aware of all state and federal legislation and laws affecting the health of citizens of Illinois and the practice of medicine in Illinois,
2. Promulgate legislation to improve the health care of citizens of Illinois and the practice of medicine in Illinois,
3. Cooperate with the AMA in similar programs.
4. Develop programs to educate the public and the Illinois State Medical Society membership in the privileges and responsibilities of citizenship.

### COMMITTEES:

Public Affairs  
Eye

## MEDICAL-LEGAL COUNCIL

Noel G. Shaw, *Chairman*, 2901 Central St.,  
Evanston 60201  
Clinton L. Compere, (Impartial Medical Testi-  
mony) 737 N. Michigan Ave., Chicago 60611  
William G. McCarthy, (Licensure) 13826 Lin-  
coln, Dolton 60419  
George Alvary, 1110 N. Green, McHenry 60050  
David T. Petty, 30 North Michigan Blvd., Chi-  
cago 60602  
Andrew John Toman, 6738 W. Cermak Rd.,  
Berwyn 60609  
Grover L. Seitzinger, (Laboratory Services) 812  
N. Logan Ave., Danville 61832

### CONSULTANTS:

James B. Hartney, 410 Lake St., Oak Park  
60302  
Frederic D. Lake  
1041 Michigan Ave., Evanston 60202

STAFF: Timothy D. Selleck

### Responsibilities and Purposes

The functions of the Medical Legal Council are to 1) maintain liaison with the Bar Association; 2) supervise the activities of the Council's three committees; and 3) to educate the members of the profession in medico-legal affairs.

The Council members include the Chairmen of the Licensure, IMT, and Laboratory Services Committees, to facilitate cooperation and coordination of activities. The Council further co-operates fully with the AMA for purposes of coordinating programming.

### COMMITTEES:

Licensure  
Impartial Medical Testimony  
Laboratory Services



## COUNCIL ON MENTAL HEALTH AND ADDICTION

Marshall A. Falk, *Chairman*, 4700 N. Clarendon,  
Chicago 60640

Nathaniel S. Apter, 111 N. Wabash, Chicago  
60602

Milton C. Baumann, 725 S. 2nd St., Springfield  
62704

E. Eliot Benezra, 103 Haven Rd., Elmhurst 60126

Robert S. Daniels, 6742 S. Constance Ave., Chi-  
cago 60649

Irving Frank, 135 S. Sacramento, Sycamore 60178

Abraham Gelperin, Dept. of P.M., 835 S. Wol-  
cott, Chicago 60612 (Alcoholism)

Richard J. Graff, 204 Julie Dr., Kankakee 60901

John H. McMahan, 8601 W. Main, Belleville  
62223

Walter P. Plassman, Box 552, Centralia 62801

Billie Harold Shevick, 729-3rd Ave., Moline 61265

Joseph H. Skom, 707 N. Fairbanks Ct., Chicago  
60611 (Narcotics)

Alex Spadoni, 2112 W. Jefferson, Joliet 60435

### CONSULTANTS:

Warren W. Young

10816 Parnell, Chicago 60628

Arthur F. Goodyear

142 E. Prairie, Decatur 62523

### AUXILIARY REPRESENTATIVE:

Mrs. August Martinucci, 1210 Main, Joliet  
60435

STAFF: Perry L. Smithers

### Responsibilities and Purposes

The responsibilities of this council are as follows: It shall serve as a source of information on mental health matters for the ISMS. It shall evaluate available information and make recommendations to the Board of Trustees for the position the ISMS should take on issues in this area. It shall also cooperate with institutions and voluntary health agencies in disseminating information on mental health subjects to the profession and the public. It shall be on the alert for misleading or fallacious programs and information which need correcting for the protection of the public.

The Council shall be especially concerned with the problems of alcoholism and drug abuse.

### COMMITTEES:

Alcoholism

Narcotics

## COUNCIL ON PUBLIC RELATIONS AND MEMBERSHIP SERVICES

Matthew B. Eisele, *Chairman*, 4601 State St.,  
East St. Louis 62205

Lee F. Winkler, 850 S. Fourth, Springfield 62703

Charles S. Vil, 9450 S. Francisco, Evergreen Park  
60642

Anna Marcus (Medicine and Religion), 5852 W.  
North, Chicago 60639

Paul A. Van Pernis (Insurance), 1316 Charles  
St., Rockford 61101

Charles J. Weigel, 7579 Lake St., River Forest  
60305

Henry A. Holle, 160 N. LaSalle St., Room 2000,  
Chicago 60601

### CONSULTANTS:

Paul W. Sunderland, 214 N. Sangamon  
St., Gibson City 60936

Jacob E. Reisch, 1129 S. Second St.,  
Springfield 62704

### AUXILIARY REPRESENTATIVE:

Mrs. Wilson West, 14 Oakwood Drive,  
Belleville 62223

STAFF: James Slawny

### Responsibilities and Purposes

The Council on Public Relations and Membership Services shall plan and execute programs designed to enhance the relationship between the media, clergy, general public and medical profession. Included shall be health education and socioeconomic programs believed to be in the best interest of the profession as well as the general public. The Council shall be responsible for all insurance programs sponsored by ISMS on behalf of the membership. It shall also be responsible for all other membership services.

### COMMITTEES:

Religion and Medicine

Insurance Programs

## COUNCIL ON SOCIAL AND MEDICAL SERVICES

Thomas R. Harwood, *Chairman*, 4902 Tollview Dr., Rolling Meadows 60008

Max Klinghoffer (Disaster Medical Care), 127 E. Vallette St., Elmhurst 60126

Thomas T. Turlentes (Aging), Research Hospital, Galesburg 61401

W. I. Taylor (Nursing), 28 N. Main St., Canton 61520

Henry B. Betts (Rehabilitation Services), Rehabilitation Institute of Chicago, 401 E. Ohio, Chicago 60611

Paul G. Theobald (Paramedical Groups), 1210 Towanda, Bloomington 61801

Julian Buser, 4601 State St., East St. Louis 62205

### CONSULTANTS:

William E. Adams

55 E. Erie, Chicago 60611

Charles K. Wells

117 N. 10th St., Mt. Vernon 62864

STAFF: Dan Droege

### Responsibilities and Purposes

Responsibilities of the Council on Social and Medical Services include the initiation and implementation of programs on emergency and disaster medical care, problems of the aging, liaison with other health professionals and health oriented groups. It shall also be concerned with the quality of care rendered through health care facilities, such as hospitals.

### COMMITTEES:

Aging

Disaster Medical Care

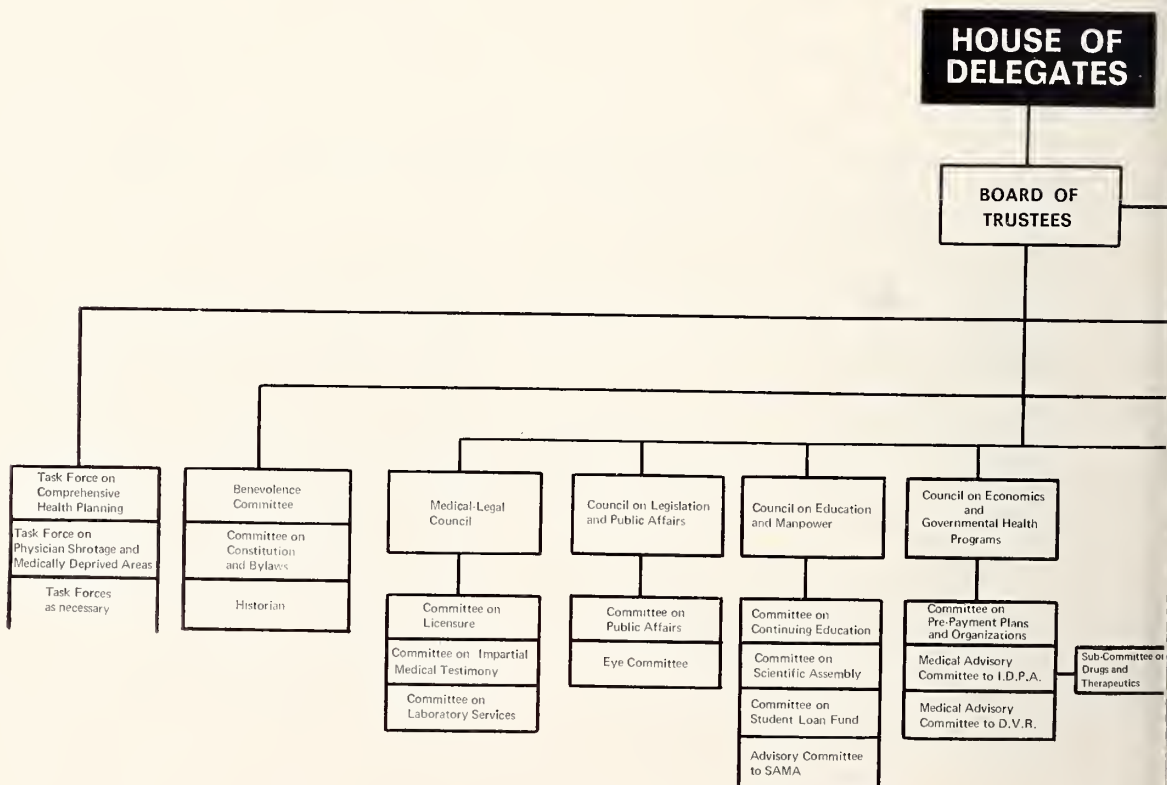
Nursing

Rehabilitation Services

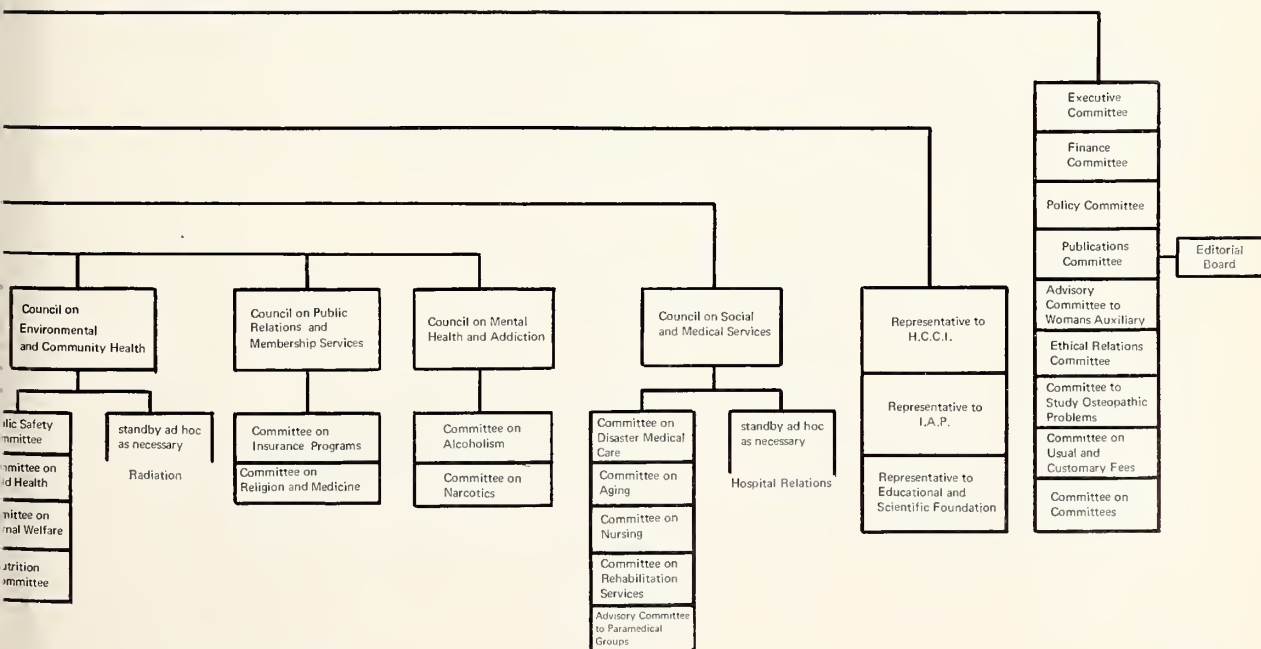
Advisory to Paramedical Groups

Ad Hoc Hospital Relations

## ISMS Organization







# COMMITTEES

The following committees have been appointed for the year 1969-1970. Each committee is assigned to a council for reporting purposes, except those that are composed entirely of trustees, or which, for reasons of efficiency and control, report directly to the Board of Trustees.

## COMMITTEE ON AGING (Council on Social and Medical Services)

Thomas T. Turlentes, *Chairman*

Galesburg Research Hospital, Galesburg 61401  
Bertram B. Moss, Jewish Home for the Aged,  
1628 S. Albany, Chicago

D. M. Roberts, 615 E. 3rd St., Alton  
Clyde Rulison, Box 38, Roberts 60962  
Martin Siefert, 1035 Forest Ave., Wilmette

### AUXILIARY REPRESENTATIVE:

Mrs. Maurice Woll, 159 S. 9th, East Alton  
62024

STAFF: Dan Droege

### Responsibilities and Purposes

The functions of the Committee on Aging encompass the broad field of aging with special consideration for the types of medical services and patterns of care available to the aging and the economics involved, promotion of positive health

and meaningful living through sound living habits, periodic health supervision, and full use of human potentials, regardless of age. The committee cooperates with the American Medical Association's Committee on Aging and other appropriate agencies.

Included among the committee's activities are the study and support of expansion of additional home care programs in Illinois; relationships with nursing homes, home nursing, homemaker programs, and other programs involving services oriented toward the aging; emphasizing preretirement planning; discouraging the mandatory retirement age and arbitrary age limits for employment whether the individual wants to continue working or not; and liaison with other agencies having a similar interest.

## COMMITTEE ON ALCOHOLISM (Council on Mental Health and Addiction)

Abraham Gelperin, *Chairman*, Dept. of P.M.,  
835 S. Wolcott, Chicago, 60612

Charles L. Anderson  
120 N. Oak St., Hinsdale, 60521

Richard S. Cook  
230 N. Michigan Ave., Chicago 60601

David J. Stinson  
2126 Jonquil Place, Rockford 61107

John C. Troxel  
222 N. Dearborn, Chicago 60601

William H. Wehrmacher  
670 N. Michigan Ave., Chicago 60611

STAFF: Perry L. Smithers

### Responsibilities and Purposes

The Committee on Alcoholism serves as an ISMS resource on alcoholism and evaluates information and makes recommendations to the Board of Trustees for the position ISMS should take on issues in this area. It cooperates with institutions, industry, government and health agencies in disseminating information on the causes, prevention, diagnosis, and treatment of alcoholism to the medical profession and the public.

## COMMITTEE ON BENEVOLENCE (Board of Trustees)

Keith H. Frankhauser, *Chairman*  
Avon 61415

Allison L. Burdick, Sr.  
5906 W. North Ave., Chicago 60639

Leo P. A. Sweeney  
10400 S. Western Ave., Chicago 60643

### AUXILIARY REPRESENTATIVE:

Mrs. Howard Lowy, 112 Pekin Ave.,  
East Peoria 61611

STAFF: Frances C. Zimmer

### Responsibilities and Purposes

The committee shall examine applications to the society for assistance to determine eligibility for benefits; keep the names of the beneficiaries confidential and known only to the committee, and recommend to the Finance Committee of the Board of Trustees the allotment of each recipient.



## COMMITTEE ON CHILD HEALTH (Council on Environmental and Community Health)

### Responsibilities and Purposes

The committee shall serve as a source of information on matters pertaining to child health. It shall evaluate available information and make recommendations to the Board of Trustees for the position the ISMS should take on issues in this area and cooperate with institutions and voluntary health agencies in disseminating information pertinent to general child health. It shall be on the alert for misleading or fallacious programs and information which need correction for the protection of the public. It shall conduct educational programs for public enlightenment for the encouragement and the establishment of school health councils; it shall strive for increased services for exceptional children. It shall conduct in cooperation with the Maternal Welfare Committee research on neonatal mortality through the state; and shall seek the formulation and adoption of uniform school health records.

Ralph H. Kunstadter, *Chairman*, 664 N. Michigan Ave., Chicago 60611  
Richard E. Dukes, 602 W. University, Urbana 61801  
W. W. Fullerton, 101 N. Market St., Sparta 62286  
Edmond R. Hess, 1737 W. Howard St., Chicago 60626  
Edward Jung, 13826 Lincoln Ave., Dolton 60419  
Edward F. Lis, 840 S. Wood St., Chicago 60612  
J. Keller Mack, 922 S. 4th St., Springfield 62702  
Franklin A. Munsey, 1429 Myott Ave., Rockford 61101  
Kenneth S. Nolan, 172 Schiller, Elmhurst 60216  
T. A. Palus, 101 Orchard Terrace, Lombard 60148  
Norman T. Welford, 656-58th St., Hinsdale 60521  
STAFF: Perry L. Smithers

## COMMITTEE ON COMMITTEES (Board of Trustees-Board Committee)

### Responsibilities and Purposes

The Committee on Committees shall review the purpose, activity and structure of all committees, and shall recommend such changes in existing committees as appear to be required for the efficient conduct of the business of the Society.

The activities of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

Darrell H. Trumpe, *Chairman*  
St. John's Sanatorium, Springfield 62707  
William A. McNichols, Jr.  
101 W. 1st St., Dixon, 61021  
Paul P. Youngberg  
1520 Seventh St., Moline 61265  
Warren W. Young  
10816 Parnell Ave., Chicago 60628  
STAFF: Frances C. Zimmer

## COMMITTEE ON CONSTITUTION AND BYLAWS (Board of Trustees)

### Responsibilities and Purposes

The Committee on Constitution and Bylaws shall

- a) Receive from individual members, county societies, committees, the Board of Trustees, and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws.
- b) Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws, and
- c) Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

Edward A. Razim, *Chairman*  
3340 S. Oak Park Ave., Berwyn 60402  
Andrew J. Brislen, 6060 Drexel, Chicago 60637  
David S. Fox, 826 East 61st, Chicago 60637  
John Ring, 511 E. Hawley, Mundelein 60060  
EX-OFFICIO: Frank Pfeifer, 510 E. Monroe St., Springfield 62705  
STAFF: Frances C. Zimmer

## COMMITTEE ON CONTINUING EDUCATION (Council on Education and Manpower)

Herschel L. Browns, *Chairman*

4600 N. Ravenswood Ave., Chicago 60640

### UPSTATE:

1st—F. H. Riordan, III, 5670 E. State St.,  
Rockford 61108

2nd—Edward K. Griffiths, 101 E. Miller Rd.,  
Sterling 61081

3rd—Herbert Sohn, 4640 N. Marine Dr.,  
Chicago 60640

4th—William R. Bertelsen, 4343 18th Ave.,  
Rock Island 61201

11th—Theodore Z. Polley, Silver Cross Hospital,  
600 Walnut, Joliet 60432

### DOWNSTATE:

5th—Robert J. Shafer, 404 W. Washington,  
Petersburg 62675

6th—Leo R. Green, 1114 Milton Rd., Alton 62002

7th—William F. Hubble, 38 S. Shore Dr.,  
Decatur 62521

8th—Gordon H. Sprague, Medical Center Clinic,  
Paris 61944

9th—James A. Felts, 517 Bainbridge, Marion  
62959

10th—Mays C. Maxwell, 4202 Bond St.,  
East St. Louis 62207

(for convenience in travel, this committee  
will meet in two sections as indicated above)

STAFF: Perry L. Smithers

### Responsibilities and Purposes

The committee is responsible for encouraging physicians of Illinois to keep abreast of medical advances by participating in various types of continuing education programs. It should be aware of the agencies offering continuing education courses, measure the value of such courses where possible and strive to coordinate them in order to prevent duplication and uncover significant gaps in types of courses available.

The committee should consider itself a monitoring arm of ISMS rather than an operational arm, except that where specific areas of continuing education are not available to Illinois physicians, it should take whatever steps are necessary to provide necessary programs.

The prime responsibility of the committee is to maintain the excellence of the profession by encouraging ISMS members to "keep up" by participating in acceptable continuing education programs.

The committee shall be responsible for operating a Scientific Speakers Bureau through which county medical societies can obtain scientific speakers for its programs.

## COMMITTEE ON DISASTER MEDICAL CARE (Council on Social and Medical Services)

Max Klinghoffer, *Chairman*

127 E. Vallette St., Elmhurst 60126

Jack R. Baldwin

1315 S. 6th St., Springfield 62703

Melvin Griem, 950 E. 59th St., Chicago 60637

William A. Hark, 30 N. Michigan, Chicago 60602

Harold C. Lueth, 636 Church St., Evanston 60201

Charles F. Sutton

505 State Office Bldg., Springfield 62706

Milton Zemlyn, 1101 George St., Chester 62233

STAFF: Marian Thiele

### Responsibilities and Purposes

The committee shall be responsible for assisting in the education of the profession and the public on the development and implementation of programs to provide medical care in the event of disaster; be responsible for directing the society's efforts toward preparedness in the event of natural or man-made catastrophes; cooperate with civil defense agencies, public health departments, hospitals, management and labor organizations, paramedical groups and other agencies to establish unity and coordination, and serve in an advisory capacity to county medical societies in medical self-help training programs and hospital disaster planning.

## SUB-COMMITTEE ON DRUGS AND THERAPEUTICS (See Public Aid, Medical Advisory Committee to The Illinois Department of) EDITORIAL BOARD (See Publications Committee)



## ETHICAL RELATIONS COMMITTEE (Board of Trustees-Board Committee)

Willard C. Scrivner, *Chairman*  
4601 State St., East St. Louis 62205  
Fredric D. Lake  
1041 Michigan Ave., Evanston 60202  
William A. McNichols, Jr.  
101 W. First St., Dixon 61021  
Darrell H. Trumpe  
St. John's Sanatorium, Springfield 62707  
STAFF: Roger N. White

### Responsibilities and Purposes

The duties of this committee are outlined in detail in the Bylaws under the chapter on "Discipline."

*Illinois State Medical Society Ethical Relations Committee.* The Board of Trustees shall appoint from its members, an Ethical Relations Committee to review matters involving the interpretation of the Principles of Medical Ethics, violations of the Constitution and Bylaws of the Illinois State Medical Society or its component societies, and charges of misconduct of members of the Society.

It shall serve as an appellate body to review cases involving these matters referred by component medical societies, and shall consider matters of law (ethics) and procedure.

*Appeals from Component Society Verdicts.* Appeals received by the Illinois State Medical Society Board of Trustees shall be referred to the Ethical Relations Committee of the Board for review. Appeals must be accompanied by pertinent data and transcripts indicating the basis for the appeal. Failure to provide such data shall be grounds for a verdict of default against the plaintiff. The committee shall notify the accused and the secretary of the component society by certified mail at least thirty days prior to the date set for the hearing of the appeal. The chairman of the committee shall preside over the hearing in accordance with the rules established by the Board of Trustees.

*Verdict.* On conclusion of the hearing, the Ethical Relations Committee of the Board of Trustees shall meet in executive session to con-

sider its decision, and shall report in writing to the Board at its next meeting for approval or rejection.

*Notification of Parties.* The secretary of the Society shall notify the defendant and the secretary of the component society wherein the defendant holds membership, of the action of the Board.

*A. Right of Appeal to the American Medical Association.* In case of findings against the accused, and in support of the action taken by the component society, the secretary of the state society shall notify the accused within ten days by certified mail of his right to appeal to the Judicial Council of the American Medical Association.

*B. Error.* In the event of a decision by the Board of Trustees of improper law (ethics) and/or procedure by the trial body of the component society, the case shall be remanded with recommendations to the component society for reconsideration.

The Committee shall be authorized by the Board of Trustees to:

- 1) Investigate
  - (a) Controversies arising under this Constitution and Bylaws and under the principles of medical ethics, to which the Society is a party, and
  - (b) Controversies between two or more county societies and their members.
- 2) Investigate all questions of medical ethics and the interpretation of the Constitution, Bylaws and Policies of the Society.
- 3) Investigate general professional conditions and all matters pertaining to the relations of physicians to one another or to the public.
- 4) To receive appeals filed by applicants who alleged that they have been denied membership in a component society because of race, creed, color, or ethnic origin, to determine the facts of the case and to report the findings to the Board of Trustees.

## EXECUTIVE COMMITTEE (Board of Trustees)

Frank J. Jirka, *Chairman*  
1507 Keystone Ave., River Forest 60305  
Edward W. Cannady, *President*  
4601 State St., East St. Louis 62205  
J. Ernest Breed, *Pres.-Elect*  
55 East Washington, Chicago 60602  
William M. Lees, *Finance*  
6518 N. Nokomis, Lincolnwood 60646

Philip G. Thomsen, *Past Pres.*  
13826 Lincoln Ave., Dolton 60419  
Jacob E. Reisch, *Secy-Treas.*  
1129 S. 2nd St., Springfield 62704  
William E. Adams, *Policy*  
55 E. Erie St., Chicago 60611

### LEGAL COUNSEL:

Frank M. Pfeifer  
STAFF: Roger N. White  
Frances C. Zimmer

### **Responsibilities and Purposes**

The Executive Committee shall consist of the president, the president-elect, the chairman of the Board, the chairman of the Finance Committee, the chairman of the Policy Committee, the secretary-treasurer and the trustee-at-large.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy Committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

## **EYE COMMITTEE** (Council on Legislation and Public Affairs)

Frank J. Kresca, *Chairman*  
208 W. Green, Champaign 61820  
James R. Fitzgerald  
6429 North Ave., Oak Park 60302  
Charles L. Pannabecker  
331 Fulton, Peoria 61602  
Lawrence J. Lawson  
636 Church St., Evanston 60201  
Wilbur W. Baumgartner  
118 N. Chestnut St., Kewanee 61443  
David V. Brown  
122 S. Michigan Ave., Chicago 60604  
Max Hirschfelder  
408-2nd St., Centralia 62801  
David Shock  
700 N. Michigan Ave., Chicago 60611  
Manuel L. Stillerman  
111 N. Wabash Ave., Chicago 60602  
Edward Kwedar  
615 S. 7th Ave., Springfield 62703

M. Byron Weisbaum  
520 E. Allen, Springfield 62703  
CONSULTANT:  
Maurice M. Hoeltgen  
1836 W. 87th St., Chicago 60620  
STAFF: Timothy D. Selleck

### **Responsibilities and Purposes**

The function of the Eye Committee is to concern itself with state legislation regarding ophthalmic matters, to secure and disseminate information and make recommendations regarding specific legislative proposals. The Eye Committee also meets with the Illinois State Joint Council of Ophthalmology to study problems and formulate policy on the medical and social-economic aspects of ophthalmology.

## **FINANCE COMMITTEE** (Board of Trustees-Board Committee)

William M. Lees, *Chairman*  
6518 N. Nokomis Ave., Lincolnwood 60646  
Mather Pfeifferberger  
State & Wall Sts., Alton 62002  
Arthur F. Goodyear  
142 E. Prairie Ave., Decatur 62523  
Jacob E. Reisch, Sec'y.-Treas.  
1129 S. 2nd St., Springfield 62704  
CONSULTANT:  
Carl E. Clark  
225 Edward St., Sycamore 60178  
STAFF: Roger N. White

### **Responsibilities and Purposes**

The Finance Committee shall consist of the secretary-treasurer of the Society and three members of the Board. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

## **AD HOC COMMITTEE ON HOSPITAL RELATIONS** (Council on Social and Medical Services)

Julian Buser, *Chairman*  
4601 State St., East St. Louis 62205  
Standby ad hoc committee; committee members to be appointed when needed.



## COMMITTEE ON IMPARTIAL MEDICAL TESTIMONY (Medical-Legal Council)

Clinton L. Compere, *Chairman*  
737 N. Michigan, Chicago 60611  
R. Gregory Green  
1355 Charles St., Rockford 61108  
Jerome J. McCullough  
110 N. High St., Belleville 62202  
Maurice D. Murfin  
250 N. Water St., Decatur 62523

CONSULTANT:  
William M. Lees  
6518 N. Nokomis, Lincolnwood 60646  
STAFF: Timothy D. Selleck

### Responsibilities and Purposes

The Committee shall cooperate with the judiciary in both federal and state courts within the state of Illinois. It shall, when requested by the court, implement the Impartial Medical Testimony panel.

## COMMITTEE ON INSURANCE (Council on Public Relations and Membership Services)

Paul A. VanPernis, *Chairman*  
1316 Charles Street, Rockford 61101  
Philip D. Boren, South Plum, Carmi 62821  
A. Everett Joslyn  
557 Keystone Ave., River Forest 60305  
James B. Flanagan  
10400 S. Western, Chicago 60643  
Lawrence Knox, 600 E. Main, Olney 62450  
STAFF: Marian Thiele

### Responsibilities and Purposes

The functions of the committee shall include its continuing review of the Tax Qualified Investment Program (Keogh); the Retirement Investment Pro-

gram; the Group Disability Program; the Group Major Medical Program; the Professional Liability Insurance Program. The committee shall continue to investigate various insurance programs that may serve to benefit members of the society.

The committee shall continue to assist in the administration of the presently sponsored disability program by performing the adjudication services provided for in the master contract.

This committee shall study insurance plans provided the membership of the Society, and shall make suggestions for changes, additions, and cancellation of policies.

## COMMITTEE ON LABORATORY SERVICES (Medical-Legal Council)

Grover L. Seitzinger, *Chairman*  
812 N. Logan, Danville 61832  
Ronald Jessen, 350 N. Wall, St., Kankakee 60901  
Jack Williams, 130 E. Randolph, Chicago 60601  
Hans Willuhn, 1335 Charles St., Rockford 61108  
John J. Mueller  
24 Logan Fairmont Addition, Alton 62002  
Peter Soto, 211 S. Third St., Belleville 62221

### CONSULTANT:

James B. Hartney  
410 Lake St., Oak Park 60302  
STAFF: Timothy D. Selleck

### Responsibilities and Purposes

The committee shall effect methods of elevating and maintaining the standards of medical laboratories in Illinois, encourage the use of medical diagnostic laboratories supervised by duly qualified physicians, and encourage each county and district to establish evaluation committees.

## COMMITTEE ON LEGISLATION (See Council on Legislation and Public Affairs)

## COMMITTEE ON LICENSURE (Medical-Legal Council)

William G. McCarthy, *Chairman*  
 13826 Lincoln Ave., Dolton 60419  
 Elliott Parker, 1630 Fifth Ave., Moline 61265  
 Wilson West, 7300 State, East St. Louis 62205  
 Ross Hutchinson  
 126 E. Ninth, Gibson City 60936  
 Raymond B. Murphy  
 R.R. 3 Box 19, Robinson 62454  
 STAFF: Timothy D. Selleck

### Responsibilities and Purposes

The committee shall concern itself with the illegal practice of medicine and other healing arts groups associated with unfounded claims for cure of disease. It shall cooperate with the legal authorities of the state, such as the office of the Attorney General and the Department of Registration and Education. It shall cooperate with the AMA's Department of Investigation and other agencies interested in this field.

## COMMITTEE ON MATERNAL WELFARE (Council on Environmental and Community Health)

Robert R. Hartman, *Chairman*  
 1515A Walnut St., Jacksonville 62650  
 Frederick H. Falls, *Chairman Emeritus & Special Consultant*  
 Box 47, River Forest 60305  
*District Member and Alternate*  
 (alternates in italics)

1. William R. Larsen  
 13707 W. Jackson, Woodstock 60098  
*Gordon T. Burns*  
 2300 N. Rockton, Rockford 61101
2. William J. Farley  
 710 Peoria St., Peru 61354  
*Donald M. Gallagher*  
 Box 538, Granville 61326
3. Melvin Goodman  
 13826 Lincoln Ave., Dolton 60419  
*Charles F. Kramer*  
 12647 Justine St., Calumet Park 60643
4. V. B. Adams  
 301 E. Jefferson, Macomb 61455  
*Ralph Gibson*  
 416 St. Marks Ct., #410, Peoria 61603
5. William W. Curtis  
 100 W. Miller Rd., Springfield 62702  
*Robert Maletich*  
 1025 S. 7th St., Springfield 62702
6. Robert R. Hartman  
 1515A Walnut St., Jacksonville 62650  
*Richard Yoder*  
 601 E. 3rd, Alton 62002
7. Paul A. Raber  
 149 W. King St., Decatur 62521  
*Hubert Magill*  
 1170 E. Riverside, Decatur 62521
8. John C. Mason Jr.  
 715 N. Logan Ave., Danville 61832

*John R. Powell*  
 602 W. University Ave., Urbana 61801

9. Harry J. Lewis  
 104 S. Maple, Benton 62812  
*Donald R. Risley*  
 319 Market St., Mt. Carmel 62863
10. James B. Stotlar  
 15 W. Walnut, Pickneyville 62274  
*William R. Malony*  
 Box 1030, Carbondale 62901
11. John J. McLaughlin  
 1000 Jefferson St., Joliet 60435  
*Charles P. Westfall*  
 172 Schiller St., Elmhurst 60126

CONSULTANTS:  
 John Louis  
 10721 S. Hoyne, Chicago 60653  
 Willard C. Scrivner  
 4601 State St., East St. Louis 62205  
 Donaldson F. Rawlings  
 500 State Office Bldg., Springfield 62706  
 Augusta Webster  
 707 N. Fairbanks Ct., Chicago 60611  
 Franklin D. Yoder  
 503 State Office Bldg., Springfield 62706  
 STAFF: Perry L. Smithers

### Responsibilities and Purposes

The committee shall cooperate with the State Department of Public Health in reducing the maternal mortality rate in Illinois. As a means of achieving this goal, it shall review all maternal deaths reported and send its evaluation of the management of the case to the attending physician. Appropriate measures should be taken to share the results of this research with those practitioners in a position to apply it for the benefit of their patients.



## COMMITTEE ON NARCOTICS (Council on Mental Health and Addiction)

Joseph H. Skom, *Chairman*, 707 N. Fairbanks Ct.,  
Chicago 60611  
Richard B. Eisenstein, 6730 South Shore Dr.,  
Chicago 60649  
H. Frank Holman, 1509 Illinois Ave., East St.  
Louis 62201  
Jerome H. Jaffee, Dept. of Psychiatry,  
950 E. 59th St., Chicago 60649  
Kermit T. Mehlinger, 3312 W. Grenshaw, Chi-  
cago 60614  
David Slight, 25 E. Washington St., Chicago 60602  
STAFF: Perry L. Smithers

### Responsibilities and Purposes

The functions of the Committee are: (1) study, research and dissemination of educational information on narcotics and hazardous substances to members of the medical profession; (2) to recommend acceptable measures for the control of distribution, the use and disposal of narcotics and hazardous substances, exclusive of radiation products but including poison control, and (3) to cooperate with official and non-official agencies in all matters pertaining to this subject.

## COMMITTEE ON NURSING (Council on Social and Medical Services)

W. I. Taylor, *Chairman*  
175 S. Main St., Canton 61520  
Raymond Firfer  
6846 W. Cermak Rd., Berwyn 60402  
Roger Sondag  
518 State Office Bldg., Springfield 62706  
H. J. Kolb, 303 Sherman, St. Joseph 61873  
CONSULTANT:  
Willard C. Scrivner  
4601 State St., East St. Louis 62205  
AUXILIARY REPRESENTATIVE:  
Mrs. Thomas Glatter  
2407 Spring Brook Ave., Rockford 61107  
STAFF: Marian Thiele

### Responsibilities and Purposes

The major objective of this committee is to establish a close professional relationship between the medical and nursing professions for the improvement of the health care of the patient. It should work with representatives of the nursing organizations to obtain sound educational programs for nurses, to improve the working relationships of the doctor and nurse in the hospital, and to help establish work patterns for nurses in the hospital which utilize the full skill of the nurse for the care of the patient. The committee should also assist in programs to recruit more graduate nurses, registered nurses, practical nurses, nurses aids and other ancillary nursing personnel.

## COMMITTEE ON NUTRITION (Council on Environmental and Community Health)

Eugene F. Diamond, *Chairman*  
11055 St. Louis, Chicago 60655  
Allen A. Filek  
1806 Maple, Box 870, Evanston 60204  
Eugene P. Johnson, 22 W. Main St., Casey 62420  
CONSULTANT:  
Paul A. Dailey  
620 N. Main St., Carrollton 62016  
STAFF: Perry L. Smithers

### Responsibilities and Purposes

The committee shall serve as a source of in-

formation on nutrition matters for the ISMS and evaluate available information and make recommendations to the Board of Trustees for the position the ISMS should take on issues in this area. It shall cooperate with institutions and voluntary health agencies in disseminating information on nutrition subjects to the profession and to the public. It shall be on the alert for misleading or fallacious programs and information which need correction for the protection of the public.

## COMMITTEE TO STUDY OSTEOPATHIC PROBLEMS (Board of Trustees-Board Committee)

Arthur F. Goodyear, *Chairman*  
142 E. Prairie Ave., Decatur 62523  
William E. Adams, 55 E. Erie, Chicago 60611  
William H. Schowengerdt  
301 E. University Ave., Champaign 61820  
Paul P. Youngberg  
1520 Seventh St., Moline 61265  
STAFF: Roger N. White

### Responsibilities and Purposes

The responsibilities of this committee are to assist in developing rapport, cooperation with and an understanding of the osteopathic profession. The committee shall study and report on the present situation in Illinois in view of recent action by the House of Delegates which permits qualified osteopaths to be members of the Medical Society.

## COMMITTEE ON PARAMEDICAL GROUPS (Council on Social and Medical Services)

Paul G. Theobald, *Chairman*  
1210 Towanda, Bloomington 61801  
Edward J. Krol, 4255 W. 63rd St., Chicago 60629  
Burton Krimmer  
5736 W. North Avenue, Chicago 60639  
Robert E. Lynn, 209 Henry St., Alton 62002  
Maynard I. Shapiro  
7531 Stony Island, Chicago 60649

### CONSULTANT:

Carl Clark  
225 Edward St., Sycamore 60178

STAFF: Marian Thiele

### Responsibilities and Purposes

The Advisory Committee to Paramedical Groups serves as liaison between the Illinois State Medical Society and all allied health organizations. It shall also advise and assist these organizations in the development of new financial resources needed to maintain their operations.

## POLICY COMMITTEE (Board of Trustees-Board Committee)

William E. Adams, *Chairman*  
55 E. Erie St., Chicago 60611  
Arthur F. Goodyear  
142 E. Prairie Ave., Decatur 62523  
James Hartney, 410 Lake St., Oak Park 60302  
STAFF: Frances C. Zimmer

### Responsibilities and Purposes

The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society.

## COMMITTEE ON PREPAYMENT PLANS AND ORGANIZATIONS (Council on Economics and Governmental Health Programs)

Theodore Wachowski, *Chairman*  
310 Ellis Ave., Wheaton 60187  
Donald Casely, 833 S. Wood, Chicago 60612  
James P. FitzGibbons  
4753 N. Broadway, Chicago 60640  
B. A. Kinsman  
Box 349, Professional Bldg., DeQuoin 62832  
Philip Lynch, 1314 N. Main, Decatur 62526  
Peter Starrett  
143 S. Lincoln Ave., Aurora 60505  
CONSULTANT:  
Jacob E. Reisch  
1129 S. 2nd St., Springfield 62704  
STAFF: Joseph Lotharius

### Responsibilities and Purposes

The function of the committee is to provide a channel of communication between the health insurance industry, Blue Cross-Blue Shield Plans, and the Illinois State Medical Society on matters of mutual concern. Specific problems which may arise as a result of this liaison will be referred to appropriate committees for detailed study.

It is also the committee's responsibility to establish and maintain an effective peer review mechanism to review alleged abuses in government health programs. It shall implement this charge by activating county and district prepayment plans committees to handle all review cases within their areas. The committee itself shall serve as an appellate body in these review cases.



**COMMITTEE ON PUBLIC AFFAIRS**  
**(Council on Legislation and Public Affairs)**

Theodore Grevas, *Chairman*

1800 Third Ave., Rock Island 61201

Alfred J. Faber, *co-chairman*

2110 Swainwood Dr., Glenview 60025

William F. Ashley

6545 W. 33rd St., Berwyn 60402

William W. Boswell

2500 N. Rockton Ave., Rockford 61103

Herschel L. Browns

4600 N. Ravenswood Ave., Chicago 60640

James E. Coeur, 630 Locust St., Carthage 62321

Edwin L. Falloon

9534 S. Central Park, Evergreen Park 60642

Justin Fleischmann

320 S. Ela Road, Palatine 60067

George J. Gertz, 2376 E. 71st St., Chicago 60649

A. Z. Goldstein, Rosiclare 62982

P. H. Heller

1173 Algonquin Road, Des Plaines 60018

William J. Hillstrom

280 Virginia Ave., Crystal Lake 60014

Robert P. Hohf, 2500 Ridge, Evanston 60201

Earl V. Klaren, 158 E. Cook St., Libertyville 60048

W. Robert Malony

Carbondale Clinic, Carbondale 62901

John W. Ovitz, Jr.

204 W. Elm St., Sycamore 60178

Paul A. Raber, 149 W. King St., Decatur 62521

James D. Rogers, 120 Scott St., Joliet 62401

Peter C. Rumore

401 N. Mulberry St., Effingham 62401

Stanley E. Ruzich

9944 S. Damen, Chicago 60643

James H. Ryan

1309 E. Court St., Kankakee 60901

John L. Savage, 723 Elm St., Winnetka 60093

Julius P. Schweitzer

120 Oakbrook Mall, Oak Brook 60521

D. William Sherrick

2325 Sylvan Rd., Springfield 62704

Eugene H. Siegel

103 Haven Rd., Elmhurst 60126

Lorin D. Whittaker

840 Jefferson Building, Peoria 61602

Herbert Sohn

4640 N. Marine Dr., Chicago 60640

Frederick Weiss, 15318 Center Ave., Harvey 60426

**CONSULTANTS:**

Frank J. Jirka, Jr.

1507 Keystone Ave., River Forest 60305

Philip G. Thomsen

13826 Lincoln Ave., Dolton 60419

**AUXILIARY REPRESENTATIVE:**

Mrs. David Kweder

1432 N. Sheridan Rd., Waukegan 60085

**STAFF:** Arthur W. Seeds

**Responsibilities and Purposes**

The Public Affairs Committee is concerned with the political process as it pertains to medicine and public health. Within this broad context, appropriate education of the public is basic to continue health improvement in a free society. The electorate must make its wishes known to public officials.

The Public Affairs Committee shall strive to generate interest in the overall field of politics to enable the physician to participate effectively. Programs of public affairs orientation, political education and campaign characteristics will be undertaken to increase the effectiveness of the physician in public affairs.

**MEDICAL ADVISORY COMMITTEE TO**  
**THE ILLINOIS DEPARTMENT OF PUBLIC AID**  
**(Council on Economics and Governmental Health Programs)**

Rex O. McMorris, *Chairman*

619 N. East Glen Oak Ave., Peoria 61603

Fred A. Tworoger, *Co-Chairman*

4753 Broadway, Chicago 60640

Charles E. Baldree, Jr., *Co-Chairman*

26 E. Washington St., Belleville 62220

Louis Arp, Jr., 1409 6th Ave., Moline 61265

James R. Cooper

1416 Maine St., Quincy 62301

Earl Frederick

11045 S. Vincennes, Chicago 60643

Paul LaFata, 2412 S. Glenwood, Springfield 62704

George F. Lull, 2440 N. Lakeview, Chicago 60614

George T. Mitchell

116 S. 5th St., Marshall 62441

Robert C. Muehrcke

518 N. Austin Blvd., Oak Park 60302

Alphonse L. Robinson

104 N. Front, Mounds 62964

R. Kent Swedlund

125 S. Fourth St., Watseka 60970

**CONSULTANT:**

Jacob E. Reisch

1129 S. 2nd St., Springfield 62704

Philip G. Thomsen

13826 Lincoln Ave., Dolton 60419

**STAFF:** Joseph Lotharius

### **Responsibilities and Purposes**

The Medical Advisory Committee meets at regular intervals with the staff of the Illinois Department of Public Aid to perform functions necessary to the operation of the medical program under public aid. The committee renders advisory decisions on matters of medical policy in the administration of the quality, quantity, and cost standards of the various public aid programs. The committee operates in conjunction with an estab-

lished system of county medical advisory committees and serves as a final reviewing body. It provides a channel of communication between physicians and the Department of Public Aid and strives to foster mutual understanding and good relationships.

The committee's functions also include a continuing program of education of physicians to familiarize them with the administrative details of public aid programs.

## **SUB-COMMITTEE ON DRUGS AND THERAPEUTICS**

Robert C. Muehrcke, *Chairman*

518 N. Austin Blvd., Oak Park 60302

Joseph Cece

120 Oakbrook Center, Oak Brook 60521

Charles R. Frazer, Jr.

1401 Gaty Ave., East St. Louis 62201

Richard L. Landau

950 E. 59th St., Chicago 60637

Kenneth Kessel

9042 W. 31st St., Brookfield 60513

### **CONSULTANT:**

Louis Gdalmán, R.Ph.

1753 W. Congress St., Chicago 60612

STAFF: Mrs. Pat Uznanski

### **Responsibilities and Purposes**

The committee will operate as a sub-committee of the Advisory Committee to the Illinois Department of Public Aid and will continue to work with the department in an effort to keep the Drug Manual current and effective. When suggestions and comments from the members are submitted to the committee, it will review them and present them to the Department of Public Aid when necessary. The committee will also consider other drug matters affecting the policy of the medical society.

## **COMMITTEE ON PUBLIC SAFETY (Council on Environmental and Community Health)**

James P. Campbell, *Chairman*

322 N. Blanchard St., Wheaton 60187

Edward W. Holmblad

1350 N. Lake Shore Dr., Chicago 60610

Julius M. Kowalski

436 Park Ave., Princeton 61356

Norman J. Rose

400 S. Spring St., Springfield 62706

William J. Schnute

737 N. Michigan Ave., Chicago 60611

Clifford P. Sullivan

2800 W. 87th St., Chicago 60652

### **AUXILIARY REPRESENTATIVE:**

Mrs. Arthur A. Smith

206 Country Club Ln., Belleville 62223

STAFF: Perry L. Smithers

### **Responsibilities and Purposes**

The Committee shall study the medical aspects of accident prevention; alert the public to seasonal health hazards; and co-operate with the Illinois Department of Public Health, the National Safety Council and similar organizations.



**PUBLICATIONS COMMITTEE**  
**(Board of Trustees-Board Committee)**

Jacob E. Reisch, *Chairman*  
1129 S. 2nd St., Springfield 62704  
Fredric D. Lake  
1041 Michigan Ave., Evanston 60202  
C. K. Wells, 117 N. 10th St. Mt. Vernon 62864  
Warren W. Young  
10816 Parnell Ave., Chicago 60628  
STAFF: Richard A. Ott

**Responsibilities and Purposes**

The Publications Committee shall be composed of members of the Board of Trustees, and shall be responsible for the production of the Illinois Medical Journal and other Society publications.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the Journal. It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, and standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the Journal.

**EDITORIAL BOARD**  
**(Sub-Committee of Publications Committee)**

Harvey Kravitz, *Chairman*  
5830 Dempster, Morton Grove 60053  
Charles Mrazek  
1210 Robin Hood Lane, LaGrange Park 60525  
C. J. Mueller, 108 W. 4th St., Sterling 61081  
Frederick Steigman  
1825 W. Harrison St., Chicago 60612  
Frederick Stenn  
6400 S. Kedzie Ave., Chicago 60629  
Arkell M. Vaughn  
9012 S. Leavitt Ave., Chicago 60643  
EDITOR: Theodore R. Van Dellen  
1000 Lake Shore Plaza, Chicago 60611  
STAFF: Richard A. Ott

**Responsibilities and Purposes**

The responsibilities of this committee lie in the area of the editorial content of the *Illinois Medical Journal*, and it will function as a sub-committee of the Journal Committee. It shall make recommendations to the editor concerning the scientific content, regular features and subjects of special interest to the members. It shall serve as a review board for manuscripts which the editor believes require special medical evaluation. It shall assist the editor in any way possible to obtain and present medical manuscripts of the highest quality and maximum interest to the physicians of Illinois.

**AD HOC COMMITTEE ON RADIATION**  
**(Council on Environmental and Community Health)**

Howard C. Burkhead, *Chairman*  
2650 Ridge Ave., Evanston 60201  
Standby ad hoc committee; committee members to be appointed when needed.

**COMMITTEE ON REHABILITATION SERVICES**  
**(Council on Social and Medical Services)**

Henry B. Betts, *Co-Chairman*  
401 E. Ohio St., Chicago 60611  
Joel Rosen, *Co-Chairman*  
3950 N. Lake Shore Dr., Chicago 60613  
Bruce C. Ehmke,  
Suite 1112, 411 Hamilton Blvd., Peoria 61602  
John E. Finch  
135 S. Kenilworth, Elmhurst 60126  
Frank B. Kelly, Jr.  
122 S. Michigan Ave., Chicago 60603  
Joseph L. Koczur  
10039 Turner, Evergreen Park, Chicago 60642

John G. Meyer  
413 W. Monroe, Springfield 62704  
Arthur A. Rodriguez  
12800 93rd Ave., Box 35, Palos Park 60604  
CONSULTANT:  
Frank J. Jirka, Jr.  
1507 Keystone Ave., River Forest 60305  
STAFF: Dan Droegge

### Responsibilities and Purposes

The committee shall render assistance to public and private agencies in the establishment of policies regarding rehabilitation facilities to be used and selection of patients for these services; encourage the training of rehabilitation personnel, thereby promulgating high quality care; and assist when possible to see that adequate medically su-

pervised rehabilitation services be made available in all hospitals, according to the need of the hospitals.

The committee also works closely with the Governor's Committee on Employment of the Handicapped when called upon for its advice and counsel.

## COMMITTEE ON RELIGION AND MEDICINE (Council on Public Relations and Membership Services)

Anna A. Marcus, *Chairman*

5852 W. North Ave., Chicago 60639

Robert S. Mendelsohn,

1100 Hull Terrace, Evanston 60202

Clement P. Cunningham

2526 18th Ave., Rock Island 61201

Charles W. Pfister

5511 N. Harlem Ave., Chicago 60656

The Very Rev. Msgr. Armand J. Rotondi (M.D.)

405 Lockport, Plainfield 60544

William H. Whiting

Box 410, 525 N. Main St., Anna 62906

#### CONSULTANTS:

Rev. Herman Cook

Chaplain's Department, Univ. of Chicago  
Hospitals and Clinics, 950 E. 59th St.,  
Chicago 60637

#### AUXILIARY REPRESENTATIVE:

Mrs. John W. Koenig

2518 Oakwood Drive, Olympia Fields  
60461

STAFF: Dan Droege

### Responsibilities and Purposes

The committee is responsible for the development of effective lines of communication between the physicians and the clergymen leading to the most effective care and treatment of the patient and his family.

## COMMITTEE ON SCIENTIFIC ASSEMBLY (Council on Education and Manpower)

Robert T. Fox, *Chairman*

2136 Robin Crest Ln., Glenview 60025

J. Robert Thompson, *Director of Exhibits*

5601 N. Pulaski Rd., Chicago 60646

Elizabeth A. McGrew

1853 W. Polk St., Chicago 60612

Ira M. Rosenthal

700 S. Wood St., Chicago 60612

Donald L. Unger

2474 Dempster St., Des Plaines 60016

#### AUXILIARY REPRESENTATIVE:

Mrs. Paul Palmer

1511 Bigelow, Peoria 61604

STAFF: Perry L. Smithers

### Responsibilities and Purposes

The Committee on Scientific Assembly shall coordinate the program for the Annual Convention in accordance with Chapter II of the Constitution and Bylaws-*Annual Convention*; it shall appoint, with the approval of the Board of Trustees, a secret committee to make awards to the scientific exhibitors; may incorporate in the annual scientific meeting those meetings of medical specialty groups which wish to affiliate with the ISMS annual convention, and shall arrange for the annual banquet and other functions held during the annual convention.

The scientific program shall be conceived by the Committee on Scientific Assembly and developed and implemented through the joint efforts of the Committee on Scientific Assembly and representatives of specialty groups.



## ADVISORY COMMITTEE TO THE STUDENT AMERICAN MEDICAL ASSOCIATION (Council on Education and Manpower)

Norman Frank, *Chairman*

421 Park Avenue, Clarendon Hills, 60514

Allison L. Burdick, Jr.

5906 W. North Ave., Chicago 60639

T. Howard Clarke

251 E. Chicago Ave., Chicago 60611

N. Kenneth Furlong

221 N. Glen Oak Ave., Peoria 61603

Nathan Iglitzen

Illinois Masonic Medical Center

836 W. Wellington, Chicago 60657

Jerry Ingalls, 502 Shaw Ave., Paris 61944

Courtney P. Jones

11045 S. Vincennes, Chicago 60643

Louis Limarzi, 910 N. East Ave., Oak Park 60302

AUXILIARY REPRESENTATIVE:

Mrs. Mitchell Spellberg

7408 S. Clyde, Chicago 60649

STAFF: Perry L. Smithers

### Responsibilities and Purposes

The committee is charged with the responsibility of maintaining liaison with officers of Student AMA Chapters in Illinois; establishing programs to acquaint medical students with the principles of organized medicine; and developing programs designed to advance the purposes of both organizations.

## COMMITTEE ON STUDENT LOAN FUND (Council on Education and Manpower)

Donald Stehr, *Chairman*

102 E. Market, Havana 62644

Jack Gibbs, 24-26 Main St., Canton, 61520

Charles Salesman

1201 N. Allen St., Robinson 62454

CONSULTANT:

Jacob E. Reisch

1129 S. 2nd St., Springfield 62704

STAFF: Perry L. Smithers

### Responsibilities and Purposes

The committee shall be responsible to the Board of Trustees in matters related to administration of the Student Loan Program operated jointly with the Illinois Agricultural Association.

## COMMITTEE ON USUAL AND CUSTOMARY FEES (Board of Trustees-Board Committee)

Joseph R. O'Donnell, *Chairman*

444 Park Blvd., Glen Ellyn 60137

Philip G. Thomsen, 13826 Lincoln, Dolton 60419

Mather Pfeifferberger

State and Wall Sts., Alton 62002

James B. Hartney

410 Lake St., Oak Park 60302

Joseph L. Bordenave

1665 South St., Geneva 60134

CONSULTANTS:

Jacob E. Reisch

1129 S. 2nd St., Springfield 62704

George Shropshear

1525 E. 53rd, Chicago 60615

STAFF: James Slawny

### Responsibilities and Purposes

The Committee on Usual & Customary Fees shall define the concepts of usual, customary, and reasonable fees, and develop guidelines for the implementation of these concepts at the county, district, and state society level. In carrying out the directive that physicians be reimbursed on the basis of their usual and customary fees without reference to existing fee schedules, the committee meets with representatives of health insurance carriers, government intermediaries, and government agencies who pay for medical services, and reviews the adequacy and appropriateness of physician reimbursement in accordance with the position of the Board of Trustees and the House of Delegates.

**ADVISORY COMMITTEE TO THE DIVISION  
OF VOCATIONAL REHABILITATION  
(Council on Economics and Governmental Health Programs)**

Eli Borkon, *Chairman*

Box 1030, Carbondale 62901

Joseph Compton

4601 State St., East St. Louis 62205

Thomas R. Glatter

6670 E. State St., Rockford 61108

Harry Grant

701 N. Walnut, Springfield 62702

Brian H. Huncke

1725 W. Harrison, Chicago 60612

Thaddeus S. Pierce

3340 S. Oak Park, Berwyn 60403

Aaron M. Rosenthal

1401 California, Chicago 60608

Harold A. Sofield

715 Lake, Oak Park 60302

A. Walter Wise

502 Safety Bldg., Rock Island 61201

CONSULTANT:

Frank J. Jirka, Jr.

1507 Keystone Ave., River Forest 60305

STAFF: Joseph Lotharius

**Responsibilities and Purposes**

The Advisory Committee to the Division of Vocational Rehabilitation should meet at regular intervals with the staff of the Division of Vocational Rehabilitation to perform functions necessary to the operation of the medical program under DVR. The committee renders advisory decisions on matters of medical policy in the administration of the quality, quantity, and cost standards of the various DVR programs. The committee provides a channel of communication between physicians and the Division of Vocational Rehabilitation and strives to foster mutual understanding and good relationships.

The committee's functions also include a continuing program of education of physicians to familiarize them with the administrative details of DVR programs.

**ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY  
(Board of Trustees-Board Committee)**

J. Ernest Breed, *Chairman*

55 East Washington, Chicago 60602

Edward W. Cannady

4601 State St., E. St. Louis 62205

Frank J. Jirka, Jr.

1507 Keystone Ave., River Forest 60305

STAFF: Roger N. White

**Responsibilities and Purposes**

The committee shall consist of the president-elect as chairman, the president, the chairman of the board. The committee shall provide advice and assistance to the president of the Woman's Auxiliary in her program for the year, and shall assist her in interpreting the activities of the state medical society to the auxiliary members.

**TASK FORCES**

To consider specific activities and give full concentration of council and staff effort to a single problem, task forces will be formed. These will function until the objective has been met and will then be dissolved. Said groups will cross functions with many councils and committees and will consist of members of other councils and committees. They will report directly to the Board of Trustees.

**TASK FORCE ON  
COMPREHENSIVE HEALTH PLANNING  
(Board of Trustees)**

V. P. Siegel, *Chairman*

4601 State St., East St. Louis 62205

Thomas P. deGraffenried

1208 Sunnymede, DeKalb 60115

John Howard Kendall

502 W. Palladium Dr., Joliet 60431

Philip Lynch, 1314 North Main, Decatur 62526

E. A. Piszczek

6410 N. Leona Ave., Chicago 60646

Fred Z. White, 723 N. Second, Chillicothe 61523

EX-OFFICIO:

Clarke Mangun, Jr.

535 N. Dearborn, Chicago 60610

(AMA)

STAFF: Timothy D. Selleck



### **FUNCTIONS OF TASK FORCE:**

- 1) To keep abreast of all developments in the State of Illinois with respect to Comprehensive Health Planning.
- 2) To make recommendations as to the manner in which ISMS can initiate and maintain a position of leadership in Comprehensive Health Planning.
- 3) To establish and maintain a close liaison with the Department of Public Health, the official state agency designated to administer the law.
- 4) To provide information on P. L. 89-749 to county medical societies and to encourage and stimulate them to take the lead in its implementation through the formation of local Comprehensive Health Planning Councils.
- 5) To examine the relationships between the Illinois State Medical Society, its component medical societies, the allied health professions, and all segments of the community, to the various levels of government in the implementation of comprehensive health planning.
- 6) To preserve, utilize and strengthen the efforts of existing voluntary health planning mechanisms.
- 7) To promote at a local level physician responsibility for utilization and efficiency of medical service and avoidance of duplication.

### **TASK FORCE ON PHYSICIAN SHORTAGE AND SERVICES TO MEDICALLY DEPRIVED AREAS (Board of Trustees)**

Philip G. Thomsen, *Chairman*

13826 Lincoln Avenue, Dolton 60419

Jack Gibbs, 24-26 Main St., Canton 61520

Morgan M. Meyer,

815 S. Main, Lombard 60148

Eugene Johnson, 22 W. Main, Casey 62420

Ralph Dolkart

707 Fairbanks Ct., Chicago 60611

Fred A. Tworoger

4753 N. Broadway, Chicago 60640

Alfred J. Faber

2110 Swainwood Dr., Glenview 60025

Matthew Eisele

4601 State St., East St. Louis 62205

#### **CONSULTANT:**

George Shropshire

1525 E. 53rd, Chicago 60615

**STAFF:** James Slawny

#### **Responsibilities and Purposes**

The primary responsibilities of the task force are to initiate and implement programs to alleviate the physician shortage in Illinois, particularly in rural areas, and to assist in the development of projects to improve the health care of people in medically deprived areas, such as urban ghettos.

## **OTHER APPOINTMENTS**

The Board of Directors of the Educational and Scientific Foundation, Historian and representatives to other organizations report directly to the Board of Trustees periodically as necessary.

### **EDUCATIONAL AND SCIENTIFIC FOUNDATION**

Philip G. Thomsen, *Chairman*

13826 Lincoln Ave., Dolton 60419

Frank J. Jirka, Jr.

1507 N. Keystone Ave., River Forest 60305

Edward W. Cannady

4601 State St., E. St. Louis 62205

Jacob E. Reisch

1129 S. 2nd St., Springfield 62704

**STAFF:** Perry Smithers

#### **Responsibilities and Purposes**

The foundation was founded to provide an administrative agency to foster the advancement of

medical science through (1) the initiation of scientific and medical research activities, (2) the collection, evaluation and dissemination of the results of research activities to the public and (3) the implementation and management of projects related to medicine for individuals or organizations seeking to inform or educate others, or to improve their own knowledge. The charter of the foundation calls for a board of directors consisting of the following officers of the Illinois State Medical Society: Immediate Past President (as chairman), Chairman of the Board of Trustees, President, and Secretary-Treasurer.

## HISTORIAN (ARCHIVIST)

H. Kenneth Scatliff  
1415 Greenleaf Ave., Chicago 60626  
STAFF: Frances C. Zimmer

### Responsibilities and Purposes

Collect and evaluate medical items and records of historical interest to the society and the public; cooperate with other associations and agencies to preserve and display such material; supervise the preparation of any written records of the society or any of its activities; and inform the Board of Trustees of those special anniversaries which should be commemorated and supervise the observance of these occasions.

## REPRESENTATIVES

### ILLINOIS ASSOCIATION OF THE PROFESSIONS (IAP)

George B. Callahan, 4 S. Genesee St., Waukegan 60085  
Edward A. Piszczek, 6410 N. Leona, Chicago 60646  
Eugene L. Vickery, 202 Schuyler, Lena 61048

### SWANBERG FOUNDATION, QUINCY

Arnell M. Vaughn, 9012 S. Leavitt, Chicago 60620

### HEALTH CAREERS COUNCIL OF ILLINOIS (HCCI)

James Hartney, 410 Lake St., Oak Park 60302 (HCCI Board)  
Allison Burdick, Jr., 5906 W. North Avenue, Chicago 60639 (HCCI Board)  
Casper Epstein, 25 East Washington, Chicago 60602 (Del. HCCI Senate)  
Carl E. Clark, 225 Edward, Sycamore 60178 (Del. HCCI Senate)

### MIDWEST REGIONAL LIBRARY ASSOCIATION

William E. Adams, 55 E. Erie St., Chicago 60611

### LIAISON TO ILLINOIS MEDICAL ASSISTANTS ASSOCIATION

Carl E. Clark, 225 Edward St., Sycamore 60178



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# ISMS SERVICES

## **Pursuit of Obligations**

PURPOSES OF THE ILLINOIS STATE MEDICAL SOCIETY ARE:

- to promote the science and art of medicine
- to protect the public health
- to evaluate standards of medical education
- to unite the medical profession behind these purposes
- to unite with similar organizations in other states and territories of the United States to form the American Medical Association.

The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

To fulfill these purposes, the Society maintains a headquarters office at 360 N. Michigan Ave., Chicago, and an office in Springfield at 520 S. Sixth St. Services of the Society, under the gen-

eral supervision of Roger N. White, Executive Administrator, are conducted by the following divisions:

Administration; Public Relations and Economics; Legislation and Public Affairs; Publications; and Educational and Scientific Services.

Many and varied are the activities of the Society in pursuit of its obligations. Some of these activities are major programs of statewide (and sometimes national) interest for all citizens; others are of special interest to doctors; still others are sponsored for specific groups or individuals.

Following are descriptions of the Society's divisions and the programs, services and publications available directly to Society members or sponsored for their benefit.

## **DIVISION OF ADMINISTRATION**

The Executive Administrator has the responsibility and the authority to provide for the smooth and efficient functioning of the Illinois State Medical Society.

The implementation of established policy, fiscal and budgetary matters, the employment of qualified personnel and the development and maintenance of personnel policies are all part of the Administrator's activities.

He maintains liaison with the Board of Trustees and assists the chairman in carrying out his duties. Close cooperation with the speaker of the House of Delegates and the officers of the Society provides a smooth and efficient atmosphere in which the Society may function. Cooperation is maintained with the Committee on Constitution and Bylaws to present to the House all suggested

changes for official action. The Administrator channels all legal inquiries and works with the General Legal Counsel to provide guidance to the officers, trustees, committee chairmen and county medical society officers.

To provide the membership of the Society with the best professional staff services available, headquarters has been set up by divisions. The Division of Administration provides the business services of the Society including the safekeeping and proper accounting for all money and securities under the guidance of the Board of Trustees, Finance Committee and the Secretary-Treasurer.

The Division also maintains the membership records and provides a computerized central dues billing and collection service for county medical societies.

## **DIVISION OF EDUCATIONAL AND SCIENTIFIC SERVICES**

### **Committee Responsibilities**

This division provides staff services for the Council on Education and Manpower, the Council on Environmental and Community Health, the Council on Mental Health and Addiction, and the ten committees assigned to these councils.

### **Annual Convention**

Similarly, the staff serves as an arm of the Committee on Scientific Assembly to arrange and produce the annual convention of ISMS. Held in

May in Chicago each year, the convention offers scientific meetings and exhibits as well as sessions of the House of Delegates.

An additional function of the division is to administer the affairs of the Educational and Scientific Foundation, a non-profit organization established to conduct educational and scientific projects related to medicine. Physicians are invited to become Fellows of the Foundation for a charter membership of \$100.



## DIVISION OF LEGISLATION AND PUBLIC AFFAIRS

As professional medicine strives to maintain the vigorous condition of the public health, the profession is vitally and intimately concerned with legislative actions of the Illinois General Assembly and the U. S. Congress which affect physicians, other members of the healing arts, and the lay public. To insure that the best health interests of the public and professional interests of the physician are served, the Division monitors all state and national legislation which affect the health of the individual and his community.

The monitoring process is designed to present the thoughtful views of professional medicine in Illinois on specific medically related pieces of legislation.

The ISMS Council on Legislation and Public Affairs acts as the clearing house for legislative proposals recommended by specialized ISMS committees; generated by allied groups; produced by special interests and introduced by representatives and senators. Such legislation is thoroughly analyzed by physician-members of the specialized ISMS committee covering the subject matter of the introduced legislation.

### Support or Oppose Legislation

Upon appropriate consideration and recommendation, legislation of medical significance in the Illinois Legislature is either supported or opposed to protect and promote the interests of the public and the profession. Pertinent subject matter testimony is presented before the House and Senate committees as the bill proceeds through the legislative process.

On-the-scene surveillance of monitored legis-

lation is maintained by ISMS legislative representatives.

Through these essential actions, ISMS plays a meaningful role in shaping legislation for the betterment of the people of Illinois.

Action similar to the above is taken with respect to bills in Congress when they have special significance to Illinois physicians. This activity is conducted in concert with the American Medical Association.

Integrated with and designed to augment the legislative activity is the Public Affairs Program. This program, executed by the Division of Legislation and Public Affairs, as directed by the ISMS Public Affairs Committee, strives to alert the physician to his role in public affairs and to involve him in effective participation in public affairs in his community, state, and nation.

### Other Activities

Divisional activities also includes other services. One of these, involving medicine, law, and the judiciary, is the administration of the Impartial Medical Testimony program. Operating in conjunction with the Supreme Court of Illinois and the Federal District Court, the services of impartial medical examiners are provided in personal injury cases.

Other facets of medical-legal interaction are explored through the Medical-Legal Council and problems resolved through liaison with committees of the judicial and the bar associations.

In addition to the foregoing, the division staffs the Committees on Laboratory Services, Licensure, and the Eye Committee.

## DIVISION OF PUBLICATIONS

The Division of Publications is charged with the total production of all printed materials and publications as well as the distribution of these items.

Principal among the publications is the official organ of the society, the *Illinois Medical Journal*. The *Journal* is mailed monthly to all members who are urged to read it to keep abreast of the scientific, economic, political, legal and social developments within the state. The editor welcomes suggestions for articles which may be of special interest to the membership. All members should consider the *IMJ* a means of communicating with fellow Illinois practitioners.

Other publications are *Pulse*, a monthly newsletter, and such other special publications, brochures, pamphlets, flyers and letters as are required by the several ISMS divisions to carry forth their mission.

Within the division responsibility is maintained for all printing and duplicating services for the society; a small in-plant print shop is maintained along with modern reproduction and collating equipment.

In addition all mail room services are provided by this division. An addressograph and graphotype are utilized as well as a small wing mauler, folder and stuffing machine, and a plate burning cabinet. Mailing is accomplished through use of computer-supplied labels and the addressograph.

Within the *Illinois Medical Journal* and for *Pulse* commercial advertising is carried. The maintenance of the records of advertisers, insertion orders, contracts, and direct communication and liaison with advertising agencies and pharmaceutical houses fall within the purview of the division. These are accomplished through an advertising manager. Through this means and the ISMS representatives the opportunity of presenting a product to members of ISMS through advertising in ISMS publications is offered.

Staff services for the Publications Committee and the Editorial Board are furnished through the division. Needs of groups affiliated with or ancillary to ISMS insofar as reproduction facilities are concerned are also handled through the division office.

## DIVISION OF PUBLIC RELATIONS AND ECONOMICS

The Public Relations and Economics Division serves both as a news outlet to the lay press, and as a source of supply for information on socio-economic and insurance matters to the membership.

With increasing frequency, the division is contacted by news writers seeking information on socio-economic, as well as scientific subjects. Its counseling services on public relations and publicity are available to any county medical society.

The division is also frequently called upon to prepare speeches, write and publish pamphlets and other materials and make them available for distribution on such subjects as public aid in Illinois, medical care financing through Social Security, and physician retirement programs.

So far as it is possible to do so, the division designs and directs research in the area of economics. Such projects have included the Relative Value and the Membership Fee Surveys.

### News Releases

A mailing list of all Illinois newspapers, radio and television stations is maintained by the division. The list is so arranged that news releases may be addressed to individual counties, and county society secretaries may avail themselves of this service.

News releases for county societies are automatically prepared by the division staff and distributed to all news outlets in the particular county whenever a county society makes use of the ISMS post-graduate education program. Other than this, the state society's staff does not prepare news releases of county society activities unless this service is specifically requested.

### Health Columns for Newspapers

Currently, ISMS presents daily public service health columns entitled "Dr. SIMS Says." These columns, offered to the 700 newspapers in Illinois, carry the logotype of Dr. "SIMS" which readily identifies the column with the Illinois State Medical Society.

Another public service column, being carried by some 300 high school newspapers throughout Illinois, is entitled "Dr. SIMS Talks to Teens." It is distributed on a monthly basis.

### Public Aid Liaison

Familiarity with the medical care programs of the Illinois Department of Public Aid and liaison with the staff of the department are other responsibilities of the Division of Public Relations and Economics. Liaison is also maintained with public and private agencies interested in the fields of aging, insurance, hospitals, and rehabilitation.

Periodically, information is prepared for physicians and the public pertaining to such medical care programs as Old Age Assistance, Aid of the Medically Indigent, and the Military Dependents' Medical Care.

The division provides staff services to the Councils on Economics and Government Health Programs and Public Relations and Membership Services, as well as the committees on: Religion and Medicine, Disaster Medical Care, Hospital Relations, Prepayment Plans, Drugs and Therapeutics, and Aging.

Also provided with staff services are advisory committees to: Paramedical Groups, and the Illinois Department of Public Aid.

## THE EDUCATIONAL & SCIENTIFIC FOUNDATION

The Educational & Scientific Foundation was founded to provide an administrative agency to foster the advancement of clinical science through:

- 1) The initiation of scientific and medical research activities.
- 2) The collection, evaluation and dissemination of the results of research activities to the public.
- 3) The implementation and management of projects related to medicine for individuals or organizations seeking to inform or educate others, or to improve their own knowledge.

The Foundation is a distinct corporate entity which has an interlocking Board with the Illinois State Medical Society. It is staffed through ISMS headquarters.



## FILMS

### Stroke—Early Restorative Measures in Your Hospital

A film entitled "Stroke—Early Restorative Measures in Your Hospital," produced by the ISMS Committee on Aging, is available from the Society.

Directed toward physicians in all general hospitals, regardless of size, the film illustrates simple and effective methods and devices used in the rehabilitation of stroke patients. It emphasizes the procedures to be instituted immediately upon the patient's admission to the hospital.

Primary purpose of the film is to inform physicians and nurses of the need for immediate action in stroke cases and to interest them in acquiring additional details for treatment through available publications or study courses. The 20-minute sound, color film illustrates a program of constructive rehabilitation which may be conducted in any hospital, however small, by an interested nurse using a minimum of equipment.

The film may be obtained from the Society on a loan basis for viewing without charge or may be purchased for \$125.

### Modern Management of Multiple Births

"Modern Management of Multiple Births" is a 16 mm. sound-color motion picture produced by the Educational and Scientific Foundation of the Illinois State Medical Society in cooperation with Lederle Laboratories Division of American Cyanamid Co.

Teaching "heart" of the film is step-by-step reconstruction of an elaborate protocol which serves as a standard of prenatal planning for

any physician faced with the management of multiple pregnancy.

For added teaching interest, the film reviews birth of identical quadruplets, showing how identity was established with major and minor blood typings, examination of placenta and fetal membranes and other procedures. There are also scenes of actual delivery of quadruplets.

Showings of the film are restricted to professional audiences. Organizations may borrow the film from Lederle Laboratories Film Library, Pearl River, N. Y., or from the Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

### The Time of Your Life

A 13-part, 16 mm., black-and-white sound film is available to industry, church and civic groups, fraternal organizations, and medical societies, dealing with planning and participating in a happy, secure retirement. Successfully aired over TV, the video tapes have been converted to film for rental or purchase at \$60 for the former and \$975 for the latter.

This is a self-contained educational package which provides a once-in-a-lifetime opportunity for organizations to reach people who might otherwise be deprived of vital training in retirement planning. Since about one out of every three Americans will be retired within a generation it is essential that this message be put across to obviate unnecessary wasting of human resources and economic resources among the retired.

The film is available through the Division of Public Relations, ISMS.

## SPECIAL PUBLICATIONS

### Pulse

*Pulse* is a monthly newsletter published by the Illinois State Medical Society under a grant from Roche Laboratories, Division of Hoffmann La-Roche, Inc. It is distributed to all doctors in the state, to members of the Woman's Auxiliary and Illinois Medical Assistants Association, and is supplied in quantity to hospitals for interns, residents and other personnel.

*Pulse* carries non-scientific news, photographs and feature materials of interest to the medical profession in Illinois. A special section is devoted to the activities of the Woman's Auxiliary.

### Comb-1 Insurance Form

Because of the variety of data required for health insurance claims, the Comb-1 Form was developed jointly by the American Medical Association and the Health Insurance Council to simplify and reduce the number of attending

physicians forms equally acceptable to the health insurance industry and the medical profession.

Information requested by many diverse forms from a large number of insurance companies was first classified and minimum needs for claim purposes were determined. Then appropriate and clearly worded questions were developed and arranged in a standard sequence, to facilitate completion. Out of this came two basic forms, one for group health insurance and one for individual health insurance, and four abbreviated forms. A further simplification involved devising an all-purpose form which is a combination of the group and individual forms—the Comb-1 Simplified Health Insurance Claim Form.

These forms are available to physicians from the Illinois State Medical Society and should be substituted for any non-standardized forms received. Each physician has been asked to voluntarily adopt the following procedure:

1) When a physician receives a form from an

insurance company bearing the HIC symbol it should be completed and returned to the company.

- 2) When a physician receives a form *not* identified by the HIC symbol, the standardized form should be filled out and clipped to the unacceptable form with both forms returned to the insurance company.
- 3) If the insurance company insists upon having its own form completed, the doctor should feel justified in making a reasonable charge for the added work involved in handling the non-standardized form.

The attempt to standardize these forms is an aid in cutting back on the ever-increasing load of paper work involved in medical practice. Forms are available without charge from the ISMS Division of Public Relations and Economics while the supply lasts.

### Disaster Hospital Manual

The responsibility of providing immediate medical and hospital care in disasters of any magnitude falls directly on physicians, nurses and hospitals. To aid Illinois communities in developing

disaster plans, the ISMS Committee on Disaster Medical Care has adopted a model emergency plan for hospitals.

Originally developed by the Memorial Hospital of DuPage County, Elmhurst, the plan is recognized as a model by the Office of Defense Mobilization in Washington, D. C. Copies are available from the Society.

### Medical Career Recruitment Programs

As man has advanced his life expectancy, it follows that many additional young men and women are and will be needed as members of the health team. Youth must be counseled early in their academic years in order to receive the proper educational background for a doctorate of medicine or allied health field degree.

The Woman's Auxiliary of the ISMS has been the spearhead force in Illinois to interest and recruit the youth of the state in medical careers. Members are asked to aid this effort by investigating the possibility of conducting or participating in career days in their home communities.

A paperback book entitled "Horizons Unlimited" is available from the Society.

## SCIENTIFIC SPEAKERS BUREAU

The Illinois State Medical Society, through its Scientific Speakers Bureau, aids county societies in their efforts to keep members abreast of medical advances. Sponsored by the ISMS Committee on Continuing Education, the bureau helps local groups arrange and conduct postgraduate medical education programs in their own areas. This assistance includes obtaining speakers, helping them with travel arrangements, preparing and mailing notices of meetings, and paying an honorarium and travel expenses. ISMS can also provide publicity services upon request.

It also pays a \$50 honorarium and expenses for individual speakers obtained by county medical societies for their regular meetings.

The Bureau operates under a grant from Merck, Sharp & Dohme, which provides funds to the ISMS Educational and Scientific Foundation for the specific purpose of obtaining speakers for county medical society meetings.

The following procedures govern use of the Bureau:

- 1) County societies select speakers from a roster containing the names of more than 400 speakers and over 1,000 topics.

- 2) Eight weeks advance notice is required for postgraduate meetings. Requests for such meetings, which usually are scheduled for an entire afternoon, should be sent to the chairman of the Committee on Continuing Education, Illinois State Medical Society, 360 N. Michigan Ave., Chicago.

- 3) Publicity to media in the area of the meeting will be handled by ISMS upon request of the county society.

- 4) Postcard notices will be mailed to physicians in the county if requested. ISMS will prepare and mail notices if the information is received no less than three weeks prior to the meeting.

- 5) The county medical society program chairman and the speaker are both expected to submit to ISMS a report on the meeting and the arrangements.

## PHYSICIANS PLACEMENT & STUDENT LOAN FUND PROGRAM

The Illinois State Medical Society not only offers help to students who wish to become physicians, but also is able to assist the careers of those already licensed to practice medicine.

The society provides this aid through two special activities. First is its own Physicians Placement Service. Second is the Illinois Medical Student Loan Fund Program that the society sponsors in conjunction with the Illinois Agricultural Association.



## Physicians Placement Service

The Physicians Placement Service is designed to help physicians find a desirable area in which to establish practice or to relocate. The program's purpose is twofold, since it is interested also in helping those communities which demonstrate need of a resident physician.

More than 400 medical doctors have been placed through this program since its inception shortly after World War II.

The Physicians Placement Service maintains an up-to-date listing of some 150 "open" areas needing general practitioners. It maintains a similar listing of areas in need of specialists in a given field.

This service accepts requests from both physicians and communities for satisfactory placement. In addition, physicians are referred to the service by a number of organizations, among them the American Medical Association, the Illinois State Health Department and the Illinois Agricultural Association. Frequently, responsible citizens or

overburdened physicians in a community will contact the service.

Another important function of the Physicians Placement Service is to assist small communities in developing programs to attract physicians.

The Physicians Placement Service sends a questionnaire to the applicant physician to obtain information on his educational background, his interests and preferences of type of practice. Upon return of the questionnaire, the physician is sent a complete list of openings. Each opening is detailed on its facilities for home life, office space, proximity to hospital facilities and other specifics. The physician is also sent bulletins with information on new locations as they develop.

The Physicians Placement Service offers its assistance to all qualified physicians who request it. An applicant need not be a member of the state medical society. There is no charge either to the physician or to the community seeking the services of this program.

## Illinois Medical Student Loan Fund Program

The Illinois Medical Student Loan Fund Program is designed to help those who have what it takes to become a physician but lack sufficient financial resources or a recommendation for medical school. Since its inception in 1948, the program has helped over 125 qualified applicants to hurdle financial or borderline academic barriers to a medical education.

Loans to students in need are provided by joint contributions from the Illinois State Medical Society and the Illinois Agricultural Association. The program offers loans of \$625 per semester—up to a total of \$6,250 over a five-year period. A two per cent interest rate is charged semi-annually from the time the loan is received. The borrower must also insure himself for the entire amount of the loan and pay premiums on the policy. However, he has four years after receipt of his M.D. degree before the first principal payment is due.

The program also offers assistance to those who may not have financial difficulties but can't get into a "Class A" medical school because their college grades are marginal. The board representing the sponsoring organizations of the program can recommend 10 candidates annually to the University of Illinois College of Medicine in Chicago. After careful screening to determine whether the applicant has the potential to make a good medical student, the board can recommend him for admittance on the basis of its investigation.

In return for this assistance from the Medical Student Loan Fund Program, the applicant must agree to practice medicine in an Illinois town—serving a rural population for five years. The applicant may select a town from an up-to-date list of communities which have demonstrated need and ability to support a physician, but choice is subject to approval by the program's board. The purpose of this agreement is to provide family doctors for the rural communities in Illinois.

To be considered for assistance from the Medical Student Loan Fund Program, an applicant must be recommended by the presidents of his home county medical society and farm bureau. Rules of eligibility require that an applicant be a male premedical student of at least three years college standing . . . an Illinois resident outside of Cook County . . . and that he take a medical college admissions test for review by the program's board.

The board of the Medical Student Loan Fund Program conducts its annual interview about Dec. 1 for those students who wish to enter medical school the following September. Those approved for assistance are accepted on a comparative and competitive basis. Information and applications may be obtained from Roy E. Will, secretary, Joint Medical Student Loan Fund Board, Illinois Agricultural Association, 1701 Towanda Ave., P.O. Box 901, Bloomington.

## IMPARTIAL MEDICAL TESTIMONY

The Impartial Medical Testimony program, in which the Illinois State Medical Society participates, is designed to elicit objective medical truth and facilitate the equitable disposition of injury

cases in the courts of Illinois.

As a technique of judicial administration, impartial medical testimony examiners are ordered



by the court when there is evidence of a wide divergence of medical opinion in the injury which is subject to litigation. The introduction of the IMT examiner and subsequent examination of injuries provide the court with objective, impartial medical data for use in pre-trial conferences and in jury trials.

Authorization for the use of IMT examiners was established by the introduction of Illinois Supreme Court Rule 17-2 in September, 1961.

Illinois is distinguished in this matter by being the only state which has a court rule permitting the state-wide use of impartial medical testimony. The Illinois State Medical Society played a significant role in the creation and development of the IMT program. Impartial medical testimony in

other states is limited to certain jurisdictions within the states.

The Illinois State Medical Society panel of impartial medical examiners is comprised of approximately 250 physicians who are grouped into some 20 medical specialties. Composition of the panel is reviewed annually to maintain the highest standards for the courts of Illinois. The IMT

The Illinois State Medical Society is appreciative of its role in offering, in conjunction with the Supreme Court, impartial medical service for the courts of Illinois. The IMT Committee of the state society is charged with the responsibility of maintaining the IMT panel of qualified physicians, as required by the court.

## INSURANCE PROGRAMS

### Retirement Investment Program

The Board of Trustees of the Illinois State Medical Society has approved the *Retirement Investment Program* which makes available to members a means of providing for retirement with group advantages an individual physician could not otherwise obtain. The group annuity and mutual fund portion of the program may also be used as funding vehicles for Keogh qualified investment if so desired. The Tax Qualified Retirement Program (Keogh) and the Retirement Investment Program permit balanced investments to counter economic fluctuations.

Annuities or mutual funds alone do not meet the problems of recession and inflation, but together they do permit a sound retirement plan.

The group annuity provides a guaranteed lifetime income at retirement, serving as a hedge against periods of recession or declining prices, while the mutual fund provides an opportunity for common stock investment serving as a hedge against periods of inflation or rising prices.

A member physician wishing this type of retirement protection may obtain it through the Illinois State Medical Society. By doing so he not only receives advantages he would not otherwise have but he is able to benefit from the collective opinions and research facilities of the insurance company and the mutual fund's investment advisor.

The *Retirement Investment Program* making available the group annuity at a substantial reduction in premium, and the mutual funds, offered without sales commission load, is one of the most recent of its kind and was developed after several years of study taking into consideration other group plans and retirement alternatives.

The size of the retirement contribution, the proportion of investment between the group annuity and the mutual fund, and the retirement age are determined by the participating physician.

The Continental Illinois National Bank and Trust Co. of Chicago receives all physicians' contributions, and maintains records.

### Group Annuity

The group annuity, underwritten by the Continental Assurance Co., participates in dividends which are reinvested annually at compound interest.

The group annuity may provide an insurance death benefit and a total and permanent disability guarantee. In the event of death prior to retirement, a member's beneficiary would receive the death benefit or the cash value of the annuity whichever is greater.

Six options for settlement at retirement are available under the annuity. The most frequently chosen is the life income option which guarantees a base income for life that can never be outlived. With the increase of life expectancy there is a danger of depleting capital during advanced years. However, the group annuity assures, at least, a base or fixed income which cannot be outlived. Of equal importance, is the fact that settlement may be arranged under the group annuity to guarantee at least a return of the member's investment to his beneficiary if he elects a life income and dies shortly after retirement.

### Mutual Fund

The no load open end mutual fund, consisting primarily of common stocks, is managed by Stein Roe & Farnham of Chicago, which has been serving as investment adviser to pension and profit sharing trusts, trustees, individuals, and other investors since 1932.

The Stein Roe & Farnham Stock Fund is quoted daily in most major newspapers and the *Wall Street Journal*. The fund has no sales commissions. The investment adviser receives a quarterly management fee of  $\frac{1}{8}$  of 1 per cent of the average net asset value of the fund. Management fees are common to all mutual funds and are distinct from sales loads.

## Group Disability Program

The Illinois State Medical Society's officially approved group disability program is available to all eligible members of the ISMS up to age 70 who are regularly attending all of the usual duties of their occupation. Three different types of coverage are available under the program, with an over-70 conversion privilege.

Benefits of the program are payable regardless of any other insurance and no restrictive riders may be attached after issuance. The master contract contains a special renewal condition whereby the individual coverage cannot be terminated.

Provision has been made for an adjudication committee to advise the carrier on claims and other administrative problems. The adjudication committee will review the medical data and make recommendations regarding coverage which the insurance company might otherwise reject.

The program is explained in detail in a brochure which is available by writing to Parker, Aleshire & Co., 9933 Lawler Ave., Skokie 60076.

## Group Major Medical Expense Plan

A \$25,000 Group Major Medical Expense Plan designed for the Illinois State Medical Society has a 20% co-insurance feature and a \$500 or \$1,000 deductible, whichever the physician selects. For hospital room and board, the Plan will pay up to \$50 a day and in addition up to \$45 a day in an intensive care unit. It will pay \$20 a day in a convalescent home following release from a hospital up to 90 days. The Plan also provides maximum coverage for the insured in the event of mental illness and up to \$2,000 for dependents. It will also cover a congenital anomaly from the first day of birth after the effective date of the contract up to \$2,000.

New members joining the Society will be allowed to enroll without evidence of insurability or a health statement under age 40 within six months after notification of the Plan's availability.

The Group Major Medical Expense Plan is outstanding and will provide members with protection against catastrophic illness.

The Plan is underwritten by the Commercial Insurance Co. of Newark, N.J., and is administered by Parker, Aleshire & Co., Skokie 60076. Addi-

tional information may be obtained from the Illinois State Medical Society.

## Tax-Qualified Retirement Program

As mentioned above, the Board of Trustees has also approved the *Society's Tax-Qualified Retirement Program*, which utilizes a Continental Assurance Company Group Annuity and the Stein Roe & Farnham Stock Fund. This Program is intended for members who may find the provisions of the Keogh Act to their advantage. A recent liberalization, effective in 1968, which will allow contributions made by self-employed physicians to be fully deductible is expected to make this Program more attractive to the membership. The principal provisions of the Keogh Act are as follows:

1. A self-employed physician may set aside 10% of his net income from the practice of medicine or \$2,500.00 whichever is the lesser, each year for his own retirement.
2. A self-employed physician may deduct all of this amount from his income tax.
3. A self-employed physician must include all full time employees with three or more years service under the Plan. A full time employee is defined as an employee working twenty hours or more a week for a period of five or more months. The employee's contributions are made by the physician as a percent of salary at least equal to that percentage of net income put aside by the physician for his own retirement.
4. Funds invested under the Tax-Qualified Retirement Program accumulate tax free until distribution.

Continental Illinois National Bank & Trust Company of Chicago acts as Trustee for the Program's Annuity and Stock Fund shares and receives all physicians' contributions and maintains the Program's records.

Members wishing additional information on the Retirement Investment Program or its Keogh Act Program and the Tax-Qualified Retirement Program should write the Administrator for particulars: Paul H. Robinson, Jr., Incorporated, Administrator, ISMS Retirement Programs, 141 W. Jackson Blvd., Chicago 60604.

## PROFESSIONAL LIABILITY PROGRAM

An ISMS-Sponsored Malpractice Liability Insurance Program became available to members after it was approved by the Board of Trustees and the State of Illinois Insurance Department. All members may enroll in it at any time.

The Program was devised as an answer to the physician's complaints of arbitrary policy cancellations due to high risk specialty, age, abrupt increases in premium rates and headlong out of court settlements.

The Underwriter of the program is Employers' Group of Insurance Companies, an 83 year old Boston Firm. The administrator is Parker, Aleshire & Company, Skokie which has served ISMS on other insurance since 1946.

Here are some key features of the program:

1. Coverage is available regardless of age, area in state in which member practices, or specialty.
2. ISMS directly supervises and controls the program, in conjunction with the administra-



tor and underwriter. No policy will be declined or cancelled without just cause and a review by an ISMS designee. Any proposals for premium rate increases or other changes will be submitted to the Insurance Committee for review and acceptance. Firm steps are being taken to improve the legal climate in Illinois. No claims will be settled without the written approval of the insured. Outstanding defense counsels expert in Malpractice cases, have been retained. The legal profession has been notified that every Nuisance Claim will be fought. An educational program, emphasizes claim pre-

vention techniques and informs members of Malpractice trends.

3. Coverage up to \$1,000,000 is available.

4. Premium rates are in line with those charged by other insurers. A unique premium saving feature makes the plan especially attractive to the member engaged in Corporate practice. A better legal climate will help stabilize the rates because rates will reflect the loss experience as it occurs in Illinois.

Full details and application forms may be obtained from Parker, Aleshire & Company; 9933 North Lawler Avenue; Skokie, Illinois 60076 or by calling 312-679-1000.

## RADIO-TV PUBLIC SERVICE MATERIALS

Radio materials available from the Illinois State Medical Society include:

- 1) "Today's Health Tip"—a new 30-second health message every day. Available on records (30 messages per record) which feature the voice of Dr. "SIMS." For added local appeal scripts are also available which can be read by local announcer or physician.
- 2) "Medical Interview"—a five minute weekly interview series featuring a different doctor each week, discussing subjects on practical health matters in language the layman can understand.
- 3) "Medicine, Morals and You"—an 11-part, half hour series combining a pre-taped dramatic introduction and live interviews with physicians and clergymen who discuss such vital medical-moral issues as: abortion, narcotics addiction, contraceptive pills, suicide, and the unwed mother.

Television materials currently include one-minute animated spots on the subjects of measles, arthritis quackery, pre-school examinations, and rheumatic fever. Subsequent spots stressing preventive medicine will be produced during the course of the year.

In addition, the Division of Public Relations maintains a radio and television speakers' bureau, which obtains physician-speakers for radio and television interview shows on request.

## Doctor's Responsibility to the Press

Physicians and the press are partners in providing a line of communication between the medical profession and the public. But, the press cannot carry out its traditional responsibility in informing the public in the area of medical and patient news without the cooperation of the medical society and individual doctors. The inevitable penalty of silence by the doctors is public ignorance, misunderstanding and fear. In a democracy, public ignorance, misunderstanding and fear can be dangerous to professional freedom.

The following outline—based on a press code adopted by the Macon County Medical Society—

is suggested as a pilot guide for individual physicians and county societies in Illinois.

### Availability

1) The officers, committee chairmen or designated spokesmen of county medical societies shall be available at all times to mass media personnel to provide authentic information on medical subjects.

2) A list of current spokesmen shall be supplied by county societies to the executives of every newspaper, radio and television station in the country.

3) These spokesmen may be quoted by name. They should not be considered by their colleagues as self-seeking, since authoritative attribution is done in the best interests of the public and the profession. (In addition, physicians are private citizens and as such are the subjects of news stories in their social and civic activities just like any other citizen.)

### Physician News

Physicians, as scientists, are encouraged to give newspaper interviews and appear on radio and television programs on medical subjects. Physicians may report on new or unusual diseases or treatments within an ethical framework. In these instances, they should, whenever possible, notify their county society publicity chairman or the Illinois State Medical Society.

Physicians may be asked to comment as individuals on politically controversial subjects (such as socialized medicine). In this event, the physician should clearly indicate that he is expressing his personal viewpoint which should not be construed as a statement of medical society policy.

A medical society officer, however, should remember that any comment he makes—whether or not intended as personal viewpoint—is generally accepted as official policy.

### Patient News

As the patient's personal physician, the doctor has an obligation to respect confidences that come to him in the performance of his duty and may



not release news except with the patient's consent or those authorized to speak for him. When the press learns of the illness of private patients from other sources, the physician may cooperate with the press in answering any inquiries in the interest of accuracy and to avoid embarrassment.

When news of patients is of such a nature that it automatically falls in the public domain, physicians should feel free to release information within the framework of this code.

Patient information may be given where the nature of injuries, illness or treatment is of special interest. The report of such information shall be more in the nature of scientific information, rather than an exposé of an individual affliction.

### Pre-Retirement TV and Film Series

Recognizing the current "retirement revolution"

in which persons are retiring earlier and living longer, the ISMS Committee on Aging recently produced a 13-part, half hour weekly television series on pre-retirement planning entitled, "The Time Of Your Life."

The series—co-sponsored through a grant from Blue Shield Plan of Illinois Medical Service—features broadcast personality Norman Ross who interviews guest authorities on such vital topics as: financial and estate planning; meeting medical expenses; where to live in retirement; how to cope with physical and emotional problems; and constructive utilization of leisure time. Initially shown on Chicago television, the series is now available for loan on 16 mm. film to industries, businesses, and other organizations throughout the state and nation as a "ready made" course of instruction.

### MEDICAL SELF-HELP TRAINING PROGRAM

The Disaster Medical Care Committee of the Illinois State Medical Society strongly endorses the training of at least one person in each family on procedures to follow in the event of a medical emergency. This would be of value not only in the event of an atomic disaster, when physicians would not be available, but also in caring for other emergencies until the help of a physician can be obtained.

For this reason the Society presented "Medical Self Help Training" as an official television course

over educational Channel 11 in Chicago early in 1964 and again in 1965. Over 10,000 persons enrolled in this course. Response was so enthusiastic that films of the complete 15-part, 7½-hour series have been made available to county medical societies, industries, schools, and television stations throughout the state.

For complete information on this film course, as well as a "live" course for group study presentations, write the Public Relations Division of the state society.

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## Illinois Medical Political Action Committee (IMPAC)

The Illinois Medical Political Action Committee (IMPAC) is a voluntary, non-profit, unincorporated, permanent membership organization founded in 1960. IMPAC serves as the unified political action arm of Illinois physicians and their wives. It cooperates with others in the healing arts professions. Funds collected through IMPAC memberships, used in support of candidates, are administered independently of other professional groups. However, the program is operated in harmony with the legislative objectives of the Illinois State Medical Society. Individual participation in IMPAC is one means by which the individual physician and his wife can effectively participate in public affairs.

IMPAC participates primarily in election contests for legislative offices—both those in the Illinois General Assembly and in the U. S. Con-

gress. It cooperates, both in election efforts and in membership solicitation activities, with the American Medical Political Action Committee (AMPAC), its counterpart on the national level.

IMPAC's organization consists of a chairman, an executive committee, and a council. Political action activities are implemented by local physician support committees formed on behalf of candidates in U. S. Congressional or other legislative districts. Candidate selection and support are determined on the basis of evaluations and recommendations submitted to the council and executive committee by the local committees, thus assuring members of a "grass roots" voice in IMPAC activities.

Additional information about IMPAC may be obtained by writing: IMPAC, Suite 2010, 360 N. Michigan Ave., Chicago 60601.

# Woman's Auxiliary To The Illinois State Medical Society

"Never before in the history of the Medical profession, or in this country, has there been a greater need for all of us to work together."\*

Our theme in Illinois this year spells CHIC. *CH*ildren and *I*nvolve*m*ent in the *C*ommunity, broadening the emphasis to include the whole spectrum of family life with such programs as Health Careers, Home-Delivered Meals, Bicycle Safety, GEMS, the program to Curb Child Molestation through the "Patch the Pony" campaign, and a concerted effort to put an end to T.V. and Movie Violence.

Ours is not just a social organization—Although that too is part of our purpose, for how else can we "cultivate friendly relations among physicians families"—but rather ours is a service organization—service in a way that only we who have the vast resources of the AMA and our State Society at our disposal, can be of service to our communities. We have at our fingertips the best health education material, many times the only material available on some health problems, and we are remiss indeed—if we do not see that this is put to use in our local areas where it is needed. This the Auxiliary can and does do.

Our horizon is broad, our responsibilities great. We the State look to the counties for help and we can assure you that no task will be too humdrum or difficult.

The heartbeat of the Auxiliary begins in the county with the individuals—The very backbone of our organization lies within the county auxiliary because it is here that all the important programs begin. With dedication, conviction of purpose and perseverance we will serve the cause of medicine.

The Woman's Auxiliary to the Illinois State Medical Society is emphatically more than a Statewide Kaffe Klatch, as attested to by the Members' innumerable coordinated programs throughout the broad spectrum of community health education and safety, fund rais-

\*From Inaugural Address of our beloved late national president, Mrs. C. C. Long.

ing for health career scholarships, health manpower recruitment, and legislation . . . the very programs that need doing by our physician husbands "who don't have the time." Where would, without the help of physicians wives, be the success of mass immunization programs, health fairs, student recruitment, legislative drives? Just one eye-opener is that the Auxiliary has been the font of over \$3,000,000 in unrestricted grants to medical schools and loans to students plus another \$4,000,000 for health career financing—That's a lot of sugar, and it doesn't come in coffee cups.

This is a period when we seem to be moving into a very unpredictable future, when we are faced with very difficult and complex problems, when we are torn between conflicting demands and feelings of insecurity. We need to take stock of ourselves and ask, "What things do I really believe?" "What kind of an auxiliary would we have if every member were just like me?" "What is my responsibility as a member of auxiliary and as a citizen?"

Not that by any stretch of the imagination do I think that we can solve all the problems of our State, but I do believe that we can and should do our part for we have a responsibility, not only as doctors' wives but as citizens, to use what knowledge and what talents we have to help not only the Medical profession but this State of ours. If we won't accept this responsibility, who do you think will?

As the women behind the great men of medicine let us be aware that success is a seven letter word spelled with seven P's, planning, personality, personnel, projects, perseverance, programs and patience.

As I pledge my loyalty and devotion to you in an effort to sustain the high ideal of our organization I ask that together let us leave no stone unturned and go forward to make Illinois the First State by being CHIC.

Mrs. Sherman C. Arnold  
President

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- |   |   |
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|---|---|



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 2 Latern Lane, Springfield 62704  
 WASAMA ..... Mrs. Mitchell A. Spellberg  
 7408 S. Clyde, Chicago 60649

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 6 Carriage Lane, Danville 61832  
 Religion & Medicine ..... Mrs. John W. Koenig  
 2518 Oakwood Dr., Olympia Fields 60461

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## Illinois Medical Assistants Association

The Illinois Medical Assistants Association is just what the name implies—an association of medical assistants throughout the State of Illinois who have become an educational organization with objectives as follows: (a) To bring into one association all medical assistant organizations of the State of Illinois; (b) to provide an organization for those residing in Illinois counties where no medical assistants societies are organized; (c) to assist the physicians in improving medical public relations; (d) to maintain and advance the standards of professional employment and to give honest, loyal and efficient service to the medical profession and the public; (e) to meet from time to time to secure interchange of ideas.

The medical assistant associations are educational groups—not social. *We are not a union and any attempt to promote the unionization of this society or its members automatically forfeits the membership of the person or persons making such an attempt.*

Now the qualified medical assistant has the opportunity to pass a special board examination and thus become a "Certified Medical Assistant."

This will affect directly or indirectly every physician's office. Of note is the fact that you do not have to belong to the Association to take this examination. For further information as to qualifications necessary to take the examination write to American Association of Medical Assistants, 35 N. Dearborn St., Chicago 60610.

Local programs in the component societies of IMAA are geared to the needs of that particular area. Obviously the strictly specialist areas would have entirely different problems and educational needs than the area of the general practitioner where the office is staffed by one or two medical assistants. Hence the educational programs in your area would be decided by your own medical assistants and supervised by the doctors in your own county society.

We need you, Doctor, to encourage your medical assistants to join our association. But also you could help us by assisting us in selecting the proper educational programs which in the long run would be of most benefit to you. That is our whole purpose, to become better medical assistants so we can help you to help your patients.

## MEDICAL SCHOOLS IN THE STATE OF ILLINOIS

Chicago Medical School  
2020 W. Odgen Ave.  
Chicago, Ill. 60612

Leroy Levitt, M.D., Dean  
226-4100

University of Chicago Pritzker School of Medicine  
950 E. 59th St.  
Chicago, Ill. 60637

Leon O. Jacobson, M.D., Dean  
MU 4-6100  
MU 3-0800

Northwestern University Medical School  
303 E. Chicago Avenue  
Chicago, Ill. 60611

Richard H. Young, M.D., Dean  
649-8649

University of Illinois College of Medicine  
1853 W. Polk St.  
P.O. Box 6998  
Chicago, Ill. 60680

William Grove, M.D., Dean  
663-3500

Stritch School of Medicine—Loyola University  
1400 S. First Ave., Hines, Ill. 60141  
921-2610

John G. Masterson, M.D., Dean  
706 S. Wolcott Ave.  
Chicago, Ill. 60612  
SE 3-8040

## APPROVED SCHOOLS OF X-RAY TECHNOLOGY

ARLINGTON HTS.—Northwest Community  
Hospital

AURORA—Copley Memorial Hospital  
St. Joseph Mercy Hospital

BLOOMINGTON—Bloomington-Normal  
Hospital

BLUE ISLAND—St. Francis Hospital

CENTRALIA—St. Mary's Hospital

CHAMPAIGN—Burnham City Hospital

CHICAGO—Chicago Wesley Memorial Hospital

Cook County Graduate School of  
Medicine

Edgewater Hospital

Englewood Hospital

Evangelical Hospital

Franklin Boulevard Community  
Hospital

Grant Hospital

Henrotin Hospital

Illinois Masonic Hospital

Louis A. Weiss Memorial Hospital

Lutheran Deaconess Hospital

Michael Reese Hospital

Mt. Sinai Hospital

Norwegian-American Hospital

Presbyterian-St. Luke's Hospital

Provident Hospital

Ravenswood Hospital

Roseland Community Hospital

St. Anne's Hospital

St. Bernard's Hospital

St. Elizabeth's Hospital

St. Joseph Hospital

St. Mary of Nazareth Hospital

South Chicago Community Hospital

Woodlawn Hospital

DANVILLE—Lake View Memorial Hospital

DECATUR—Decatur and Macon County Hospital

DIXON—Dixon Public Hospital

EAST ST. LOUIS—Centreville Township Hos-  
pital

ELMHURST—Memorial Hospital of DuPage  
County

EVANSTON—St. Francis Hospital

EVERGREEN PARK—Little Company of Mary  
Hospital

GREAT LAKES—U.S. Naval Hospital

HARVEY—Ingalls Memorial Hospital

HINSDALE—Hinsdale Sanitarium and Hospital

JOLIET—Silver Cross Hospital

KANKAKEE—St. Mary's Hospital

KEWANEE—Kewanee Public Hospital

MOLINE—Luthern Hospital

Moline Public Hospital

NORTHLAKE—Triton College (Initial Approval)

OAK PARK—West Suburban Hospital

PARK RIDGE—Lutheran General Hospital

PEORIA—Methodist Hospital of Central Illinois  
St. Francis Hospital

QUINCY—Blessing Hospital

St. Mary Hospital

ROCKFORD—Rockford Memorial Hospital

St. Anthony Hospital

Swedish-American Hospital

ROCK ISLAND—St. Anthony's Hospital

SKOKIE—Skokie Valley Community Hospital

SPRINGFIELD—Memorial Hospital

St. John's Hospital

URBANA—Carle Memorial Hospital

Mercy Hospital

## APPROVED SCHOOLS OF CYTOTECHNOLOGY

CHICAGO—Michael Reese Hospital and Medical Center  
Mount Sinai Hospital Medical Center  
University of Chicago Hospitals and Clinics  
EVANSTON—Evanston Hospital  
St. Francis Hospital  
FREEPORT—Freeport Memorial Hospital  
GENEVA—Community Hospital  
HARVEY—Ingalls Memorial Hospital  
HINSDALE—Hinsdale Sanitarium and Hospital  
JOLIET—Silver Cross Hospital  
St. Joseph Hospital  
MOLINE—Moline Public Hospital  
OAK LAWN—Christ Community Hospital

OAK PARK—West Suburban Hospital  
PEORIA—Methodist Hospital, Proctor Community Hospital and St. Francis Hospital  
QUINCY—St. Mary's Hospital  
ROCKFORD—Rockford Memorial Hospital, St. Anthony Hospital and Swedish-American Hospital  
ROCK ISLAND—St. Anthony Hospital  
SPRINGFIELD—Memorial Hospital  
St. John's Hospital  
URBANA—Carle Foundation  
WAUKEGAN—St. Therese's Hospital  
WINFIELD—Central Dupage Hospital

## APPROVED SCHOOLS OF MEDICAL TECHNOLOGY

AURORA—Copley Memorial Hospital  
BELLEVILLE—St. Elizabeth Hospital  
BLUE ISLAND—St. Francis Hospital  
CHAMPAIGN—Burnham City Hospital  
CHICAGO—Alexian Brothers Hospital, Augustana Hospital, Chicago Wesley Memorial Hospital, Edgewater Hospital, Grant Hospital of Chicago, Holy Cross Hospital, Illinois Masonic Hospital, Louis A. Weiss Memorial Hospital, Michael Reese Hospital, Mount Sinai Hospital, Northwestern University Medical School, (Passavant Memorial Hospital), Presbyterian-St. Luke's Hospital, St. Anne's Hospital, St. Anthony de Padua Hospital, St. Bernard's Hospital, St. Joseph Hospital, St. Mary of Nazareth Hospital, University of Illinois School of Associated Medical Sciences and Veterans Administration Research Hospital.  
CHICAGO HEIGHTS—St. James Hospital  
DANVILLE—Lake View Memorial Hospital  
DECATUR—Decatur and Macon County Hospital and St. Mary's Hospital  
EVERGREEN PARK—Little Company of Mary Hospital  
GREAT LAKES—U.S. Naval Hospital (Initial Approval)

## APPROVED SCHOOLS OF INHALATION THERAPY

CHICAGO—Cook County Hospital, Edgewater Hospital, Presbyterian-St. Luke's Hospital (Initial Approval), University of Chicago Hospitals  
MELROSE PARK—Gottlieb Memorial Hospital  
MOLINE—Lutheran Hospital  
SPRINGFIELD—Memorial Hospital, St. John's Hospital

## APPROVED SCHOOLS FOR MEDICAL RECORD LIBRARIANS

CHICAGO—University of Illinois at the Medical Center

## APPROVED COURSE IN OCCUPATIONAL THERAPY

CHICAGO—University of Illinois College of Medicine

## APPROVED SCHOOL OF PHYSICAL THERAPY

CHICAGO—Northwestern University Medical School

## APPROVED SCHOOLS OF CERTIFIED LABORATORY ASSISTANTS

ALTON—Alton Memorial Hospital  
CHICAGO—St. Elizabeth's Hospital, Swedish Covenant Hospital and Veterans Administration West Side Hospital.  
DANVILLE—St. Elizabeth Hospital  
DIXON—Dixon Public Hospital  
ELGIN—Sherman Hospital  
EVERGREEN PARK—Little Company of Mary Hospital  
OAK PARK—Oak Park Hospital  
QUINCY—Blessing Hospital



## APPROVED SCHOOLS OF NURSING

### Associate Degree Nursing Program

A coeducational nursing program under the auspices of a junior college, two years in length and leading to an Associate Degree in Nursing. The curriculum consists of arts and sciences at the junior college level and nursing theory closely coordinated with nursing practice, under direction and supervision of the college faculty, in community hospitals and health facilities.

Graduates, both men and women, are prepared to give patient-centered care in staff nurse positions in hospitals, nursing homes and similar situations. They are prepared to cooperate and to share responsibility for the patient's welfare with other members of the nursing and health staff, and to develop their own skills through experience as practicing nurses.

#### BELLEVILLE

Belleville Junior College  
Department of Nursing  
2250 West Blvd. 62221

#### CHICAGO

Amundsen-Mayfair Junior College  
Department of Nursing  
4626 N. Knox Ave. 60630  
Crane College School of Nursing  
2250 W. VanBuren 60612  
Southeast College School of Nursing  
8600 South Anthony 60617

#### CHICAGO HEIGHTS

Prairie State College  
Department of Nursing  
10th & Dixie Highway 60411

#### CHAMPAIGN

Parkland College School of Nursing  
2 Main Street 61820

#### CICERO

J. Sterling Morton Junior College  
Department of Nursing  
2423 S. Austin Blvd. 60650

#### DIXON

Sauk Valley College School of Nursing  
River Campus, R.R. #1 61021

#### EAST PEORIA

Illinois Central College School of Nursing  
Highview Road,  
P. O. Box 2400 61611

#### ELGIN

Elgin Community College  
Department of Nursing  
373 E. Chicago St. 60120

#### ELK GROVE VILLAGE

Harper College Associate Degree  
Nursing Program  
510 Elk Grove Blvd. 60007

### General Entrance Requirements:

Good health.

High school graduation: with courses in biological and physical sciences (1-2 units of chemistry recommended) and mathematics (1-2 units recommended).

Qualification for admission to the college and the nursing curriculum.

Cost: tuition in public supported junior colleges is low, in private colleges considerably higher. Add to this: fees, books, uniforms and maintenance.

Living Arrangements: students live at home, in a college dormitory or other approved residence.

Graduate is eligible to take the state examination for licensure as a registered nurse ("R.N.").

#### HARVEY

Thornton Junior College  
Department of Nursing  
150th St. & Broadway 60164

#### JOLIET

Joliet Junior College  
201 E. Jefferson 60431

#### KANKAKEE

Kankakee Community College  
River Road 60901

#### LaSALLE

Illinois Valley Community College  
Associate Degree Nursing Program  
Fifth and Chartres 61301

#### MOLINE

Black Hawk College  
Department of Nursing  
1001 Sixteenth St. 61265

#### NORTHLAKE

Triton College  
Department of Nursing  
1000 Wolf Rd. 60164

#### OLNEY

Olney Community College  
305 N. West St. 62450

#### ROCKFORD

Rock Valley College  
Associate Degree Nursing Program  
3301 N. Mulford Rd. 61111

#### WAUKEGAN

Lake County Junior College  
2615 W. Washington 60085

## Baccalaureate Degree Nursing Program

Usually a coeducational nursing program under the auspices of a college or university, this is generally four academic or calendar years in length. The curriculum combines general education with nursing education, leading to the Bachelor of Science Degree in Nursing. Liberal education courses, such as arts and sciences, are shared with all college students. University medical centers and other related hospital and community health agencies are utilized for nursing theory and practice.

Graduates, both men and women, are prepared for beginning nursing positions in hospitals, nursing homes and community health services, and for advancement without further formal education to positions such as "nursing team" leader or head nurse. They also have the foundations for continuing personal and professional development and for graduate study and specialization in nursing.

### BLOOMINGTON

Illinois Wesleyan University  
Brokaw Collegiate School of Nursing 61701

### CHICAGO

DePaul University  
Department of Nursing  
25 E. Jackson Blvd. 60604

Loyola University  
School of Nursing  
6526 N. Sheridan Rd. 60626

North Park College  
Department of Nursing  
5125 N. Spaulding Ave. 60625

## Diploma (Hospital) Nursing Program

A nursing program under the auspices of a hospital or independent school of nursing, two to three years in length, and leading to a Diploma in Nursing. A college or university may provide some of the courses. The curriculum consists of theory and practice focused primarily on instruction and related clinical experience in the nursing care of patients in hospitals. Some liberal arts courses may be included.

Graduates, both men and women, have the understanding and skills necessary to organize and implement a plan of nursing that will meet the immediate needs of one or more patients and that will promote the restoration of health. They are also able to plan with associated health personnel for the care of patients, and may be

### ALTON

Alton Memorial Hospital  
Memorial Drive 62004

## General Entrance Requirements:

Good health.

High school graduation: college preparatory program including biology and physical sciences (1-2 units of chemistry recommended) and mathematics (1-2 units). Two years of a foreign language may be required. Meets college or university admission standards.

Cost: college or university tuition fees for nursing programs are comparable to those for other majors. Range in Illinois is from approximately \$1,000 to \$7,000 for tuition and fees for total program. Other expenses: books, uniforms, maintenance.

Living Arrangements: students live at home, in a college dormitory or other approved residence.

Graduate is eligible to take state examination for licensure as a registered nurse ("R.N.").

St. Xavier College  
School of Nursing  
103rd & Central Park 60655

University of Illinois  
College of Nursing  
808 S. Wood St. 60612  
P.O. Box 6998

### DEKALB

Northern Illinois University  
School of Nursing 60115

### EDWARDSVILLE

Southern Illinois University  
Edwardsville Campus  
Department of Nursing 62025

### KANKAKEE

Olivet Nazarene College  
Department of Nursing 60901

responsible for the direction of other members of the nursing team.

## General Entrance Requirements:

Good health.

High school graduation: Usually upper half of class, with courses in biological and physical sciences (1-2 units, one of which should be chemistry) and mathematics (1-2 units).

Satisfactory results on entrance tests and qualification for admission to the school.

Cost: \$900 to \$3,500; some include full maintenance.

Living Arrangements: Schools have residence facilities; many permit students to live at home if preferred.

Graduate is eligible to take the state examination for licensure as a registered nurse ("R.N.").

St. Joseph's Hospital  
915 E. Fifth St. 62004



AURORA			FREEPORT		
Copley Memorial Hospital			Freeport Memorial Hospital		
310 Seminary Ave.	60507		1335 W. Stephenson	61032	
BLOOMINGTON			GALESBURG		
Mennonite Hospital			Galcsburg Cottage Hospital		
804 N. East St.	61701		674 N. Seminary Ave.	61401	
CANTON			JACKSONVILLE		
Graham Hospital			Passavant Memorial Area Hospital		
210 W. Walnut St.	61520		1600 W. Walnut St.	62650	
CHAMPAIGN			JOLIET		
Burnham City Hospital			St. Joseph's Hospital		
404 S. Third St.	61822		333 N. Madison St.	60435	
CHICAGO			Silver Cross Hospital		
Augustana Hospital			600 Walnut St.	60432	
411 Dickens Ave.	60614		MOLINE		
Chicago Wesley Memorial Hospital			Lutheran Hospital		
250 E. Superior St.	60611		555 Sixth St.	61265	
Cook County Hospital			Moline Public Hospital		
1900 W. Polk St.	60612		635 Tenth Avenue	61265	
Illinois Masonic Hospital			OAK LAWN		
836 Wellington Ave.	60657		Evangelical (Christ Community Hospital)		
James Ward Thorne—			4440 W. 95th St.	60453	
Passavant Memorial Hospital			OAK PARK		
244 East Pearson St.	60611		West Suburban Hospital		
Michael Reese Hospital and Medical Center			518 N. Austin Blvd.	60302	
2816 S. Ellis Ave.	60616		PARK RIDGE		
Mount Sinai Hospital Medical Center			Lutheran General and Deaconness Hospitals		
2730 W. 15th Place	60608		1700 Western Ave.	60068	
Ravenswood Hospital			PEORIA		
1931 W. Wilson Ave.	60640		Methodist Hospital of Central Illinois		
St. Anne's Hospital			221 N.E. Glen Oak	61603	
4950 W. Thomas	60651		St. Francis Hospital		
St. Bernard's Hospital			211 Greenleaf St.	61603	
6344 S. Harvard Ave.	60621		QUINCY		
St. Mary of Nazareth Hospital			Blessing Hospital		
1127 N. Oakley Blvd.	60622		1005 Broadway	62301	
South Chicago Community Hospital			ROCKFORD		
2320 E. 93rd St.	60617		Rockford Memorial Hospital		
DANVILLE			2400 N. Rockton Ave.	61103	
Lake View Memorial Hospital			St. Anthony's Hospital		
812 N. Logan Ave.	61833		1411 E. State St.	61101	
DECATUR			Swedish-American Hospital		
Decatur Memorial Hospital			1316 Charles St.	61101	
2300 N. Edward St.	62526		ROCK ISLAND		
EVANSTON			St. Anthony's Hospital		
Evanston Hospital			767 Thirtieth St.	61201	
2645 Girard Ave.	60201		SPRINGFIELD		
St. Francis Hospital			Memorial Hospital		
319 Ridge Ave.	60202		200 W. Dodge St.	62701	
EVERGREEN PARK			St. John's Hospital		
Little Company of Mary Hospital			821 E. Mason St.	62701	
2800 W. 95th St.	60642				

## Practical Nursing Program

A coeducational nursing program under the auspices of public vocational education systems, hospitals or community agencies, usually one year in length. The curriculum includes nursing theory coordinated with nursing practice.

Graduates, both men and women, of programs in practical nursing are prepared for two roles:

(1) under the supervision of a professional nurse or physician, they give nursing care to patients in situations relatively free of scientific complexity; (2) in a close working relationship, they assist the professional nurse in giving care to patients requiring a high degree of nursing skill and judgment.

## Entrance Requirements:

Good health.

High school: Two years minimum, graduation desirable. Junior and senior students who are currently enrolled in high school are eligible to enroll in the practical nursing program as part of their credit curriculum.

Satisfactory results on entrance tests.

References and personal interview.

Cost: None under MDTA programs, to approximately \$400 plus maintenance.

Living Arrangements: Students usually live at home or in housing approved by school.

Graduate is eligible to take the state examination for licensure as a practical nurse ("L.P.N.").

## ALTON

F. W. Olin School of Practical Nursing  
2200 College Ave. 62005

## BLOOMINGTON

Bloomington School of Practical Nursing  
709 S. Clinton St. 61701

## CAIRO

Cairo School of Practical Nursing  
1615 Commercial Street 62914

## CARBONDALE

Southern Illinois University Vocational Public  
Technical Institute of Practical Nursing,  
Manpower Division (MDTA) 62901

## CHAMPAIGN

Champaign School of Practical Nursing  
103 N. Prospect Ave. 61821

## CHICAGO

Chicago Public Schools Practical Nursing  
Program, Chicago Board of Education  
1820 W. Grenshaw 60612  
Practical Nurses Training Program, Chicago  
Board of Education, Manpower Division  
(MDTA)  
2913 N. Commonwealth 60657  
St. Frances X. Cabrini School of Practical  
Nursing  
811 S. Lytle St. 60607

## DANVILLE

Danville Junior College School of Practical  
Nursing  
305 W. Madison St. 61833

## DECATUR

Decatur School of Practical Nursing  
210 W. North St. 62522

## DES PLAINES

Niles Township H. S. School of Practical  
Nursing  
1901 Potter Road 60018

## DIXON

Sauk Valley College  
River Campus—Rural Route # 1 61021

## EAST ST. LOUIS

Board of Education District 189  
School of Practical Nursing  
332 N. Ninth 62205

## GALESBURG

Galesburg Practical Nurse Program  
650 Locust St. 61401

## HARRISBURG

Southeastern Illinois College School of Prac-  
tical Nursing  
333 W. College St. 62946

## HINSDALE

Hinsdale Sanitarium and Hospital School of  
Practical Nursing  
120 N. Oak St. 60521

## JACKSONVILLE

Jacksonville Board of Education School of  
Practical Nursing  
504 E. Court St. 62650

## JOLIET

Joliet Township H.S. School of Practical  
Nursing  
201 E. Jefferson St. 60432

## KANKAKEE

Kankakee School of Practical Nursing  
293 E. Court St. 60901

## LASALLE

St. Mary's Hospital School of Practical  
Nursing  
1015 O'Connor St. 61301

## MATTOON

Lake Land Community College  
School of Practical Nursing  
1921 Richmond 61938

## MOLINE

Blackhawk College School of Practical  
Nursing  
1001-16th St. 61265

## MT. CARMEL

Wabash Valley College Practical Nursing  
Program  
2222 College Dr. 62863

## MT. VERNON

Rend Lake College  
School of Practical Nursing  
315 South 7th 62864

## OAK FOREST

Oak Forest Hospital School of Practical  
Nursing  
15900 S. Cicero 60452

## PEKIN

Pekin Practical Nurse Program  
East End High School 61554

## PEORIA

Peoria School of Practical Nursing  
509 W. High St. 61606

## QUINCY

Quincy School of Practical Nursing  
820 Vermont Street 62301

## RIVER GROVE

Triton Junior College Practical Nursing  
Program  
2000 N. Fifth Ave. 60171

## ROCKFORD

Rockford School of Practical Nursing  
201 S. Madison 61101

## SKOKIE

Niles Township H.S. School of Practical  
Nursing  
Oakton and Edens Expressway 60018

## SPRINGFIELD

Springfield School of Practical Nursing  
1300 S. Sixth St. 62704

## STREATOR

Streator Township High School  
Practical Nursing Program  
600 N. Jefferson 61364

## WAUKEGAN

Waukegan Township High School Practical  
Nurse Program  
1011 Washington St. 60085

# ILLINOIS STATE GOVERNMENT

The state government is divided into three branches—legislative, executive, and judicial. The legislative power is vested in the General Assembly, which is composed of the State Senate and the House of Representatives (a bicameral assembly).

For representation in the General Assembly, there are 58 senatorial districts and 59 representative districts. Each senate district elects one senator; each representative district elects three representatives. Thus, the Senate has 58 members and the House 177. The senators are elected for four-year terms, and the representatives serve two-year terms. Under normal procedure, Senators in the districts having even numbers are elected in Presidential election years; those in districts with odd numbers are chosen at elections in the intervening even-numbered years. However, recent requirements for reapportionment have created changes in this pattern.

The General Assembly normally meets in the first six months of each odd-numbered year. Recently, because of annual budgeting by the Administration, special sessions have been called during the even numbered years. The General Assembly's functions are to enact, amend, or repeal laws or adopt appropriation bills, act on amendments to the United States Constitution, propose and submit amendments to the State Constitution, and to act to remove public officials.

When the House of Representatives is organized, a Speaker or presiding officer is elected for the biennium. The presiding officer of the Senate is the Lieutenant Governor. To facilitate the handling of legislation, the members of the Senate and House are assigned to designated committees to consider bills of like subject matter. These committees usually hold public hearings to discuss legislation before the measure is taken up by the entire House or Senate. There are approximately 50 committees.



## EXECUTIVE BRANCH

The Constitution provides that the Executive Department shall consist of the Governor, Lieutenant Governor, Secretary of State, Auditor of Public Accounts, Treasurer, Superintendent

of Public Instruction, and Attorney General. All of these officials are elected for four-year terms. The Treasurer is the only elected state official who cannot succeed himself.

## LEGISLATIVE BRANCH

### Legislative Procedure

Each member of the General Assembly has the right to introduce bills or resolutions. After the introduction of the bill, it is referred to the appropriate committee. If the committee recommends the bill favorably, it is read a first time, usually by title, before the house in which it was introduced. A second reading must be held on a separate legislative day when amendments to it can be offered for consideration by the entire membership. The bill will then be given a third and final reading when it is acted upon by the entire membership of the house that is considering it.

### Action by Both Houses

To pass, the bill must receive the favorable vote of the majority of the members elected (89 in the House; 30 in the Senate). These bills are then sent to the other house where essentially the same procedure is followed.

If, because of amendments in the second house, there are two versions of the same bill, conference committees may be appointed to work out the differences. Both houses must vote favorably on the same version of the bill before it can be sent to the Governor for his consideration.

If the Governor thinks the bill should become a law, he can either sign it or file it with the Secretary of State without his signature. If the Governor decides it would be unwise for the bill to become law, he can veto it. If he vetoes the bill, he must file a statement of objections. Two-thirds of the members elected to the House can override the veto. He can also veto specific items of an appropriation bill.

### Appropriation Bills

"Bills making appropriations of money out of

the treasury shall specify the objects and purposes for which the same are made, and if the Governor shall not approve any one or more of the items or sections contained in any bill, but shall approve the residue thereof, it shall become a law as to the residue in like manner as if he had signed it. The Governor shall then return the bill with any objections to the items or sections of the same not approved by him to the House in which the bill shall have originated, which House shall enter the objections at large upon its journal and proceed to reconsider so much of said bill as is not approved by the Governor. Any item or section of said bill not approved by the Governor shall be passed by two-thirds of the members elected to each of the two Houses of the General Assembly, it shall become part of said law, notwithstanding the objections of the Governor. Any bill which shall not be returned by the Governor within ten days, Sundays excepted, after it shall have been presented to him, shall become a law in like manner as if he had signed it, unless the General Assembly shall, by their adjournment, prevent its return, in which case it shall be filed with his objections in the office of the Secretary of State within ten days after such adjournment or become a law." (Article V, Section 16, Illinois Constitution)

## NOTE

A Legislative Directory containing the names and address of all members of the 76th Illinois General Assembly and the Illinois Senators and Representatives in the Congress is available. Requests should be directed to: Illinois State Medical Society, Regional Office, 520 S. Sixth St., Springfield, 62701.

## STATE OFFICERS

*Governor*, RICHARD B. OGILVIE, Rep., Chicago  
*Lieutenant Governor*, PAUL M. SIMON, Dem., Troy  
*Secretary of State*, PAUL POWELL, Dem., Vienna  
*Auditor of Public Accounts*, MICHAEL J. HOWLETT, Dem., Chicago  
*State Treasurer*, ADLAI E. STEVENSON, III, Dem., Chicago

*Attorney General*, WILLIAM J. SCOTT, Rep., Evanston  
*Superintendent of Public Instruction*, RAY PAGE, Rep., Springfield  
*Clerk of the Supreme Court*, JUSTIN TAFT, Rep., Rochester

## ILLINOIS REGIONAL MEDICAL PROGRAM REGIONAL ADVISORY COMMITTEE

The Regional Medical Program for Heart Disease, Cancer, Stroke and Related Diseases was established by Congress in 1965 as Public Law 89-239. The Illinois Regional Medical Program, which began in 1967, is now incorporated by the five Illinois medical schools, the Chicago College of Osteopathy, and their major teaching hospitals. The Program seeks to improve patient care by closing the gap between science and

service. It encourages the establishment of voluntary cooperative arrangements among various health-related organizations, agencies, and institutions in the region. An Advisory Group representative of the region gives overall guidance to the Program as required by law. It must approve all project applications submitted for funding.

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### DEPARTMENT OF PUBLIC HEALTH

503 State Office Bldg., Springfield 62706  
Franklin D. Yoder, M.D., M.P.H., Director  
E. L. Wittenborn, M.P.H., Assistant to the Director

#### Division of General Administration

E. L. Wittenborn, M.P.H., Chief

##### Bureaus of:

Administration—E. L. Wittenborn, M.P.H., Chief

Accounting and Finance—Walter DeWeese Acting Chief

Electronic Data Processing—Isabelle Crawford, M.A., Chief

Health Education—Lynford L. Keyes, M.P.H., Chief

Nursing—Grace Musselman, R.N., M.P.H., Acting Chief; Alice Starr, R.N., M.A., Consultant Nurse

Vital Records—Leo A. Ozier, Chief, Deputy State Registrar; Aaron A. Vangeison, Assistant Chief and Assistant Deputy State Registrar

#### Chicago Offices

Benn J. Leland, M.S., Division of Sanitary Engineering, 1919, W. Taylor St., Chicago 60612

#### Division of Dental Health

Carl L. Sebelius, D.D.S., M.P.H., Chief

John D. Thorpe, D.D.S., M.P.H., Assistant Chief

##### Bureaus of:

Research and Special Studies, John D. Thorpe, D.D.S., M.P.H., Chief

Continuing Education—Lawrence F. Bennett, D.D.S., M.P.H.

#### Division of Foods and Drugs

Roy W. Upham, D.V.M., Chief

James V. Burke, Assistant Chief

##### Bureaus of:

Drug Control, Richard A. Wisell, M.P.H., Acting Chief

Food Sanitation Service, T. J. Flynn, Jr., M.P.H., Acting Chief

Planning, Training & Evaluation, William A. Grills, M.P.H., Chief

#### Division of Health Planning and Resource Development

Francis J. Weber, M.D., Dr.P.H., Chief

John G. Chaplin, M.Ed., Assistant Chief

#### Division of Health Care Facilities And Chronic Illnesses

R. F. Sondag, M.D., M.P.H., Chief

##### Bureaus of:

###### CHRONIC ILLNESS

William J. Cassel, Jr., M.D., M.P.H., Chief

Edith Heide, R.N., B.S., Consultant Nurse, Aging and Chronic Illness

###### CHRONIC RENAL DISEASES

Ruth Shriner, A.S.C.W., Social Service Consultant

Ted Moore, B.S., Public Health Advisor, USPHS Rheumatic Fever Control Program—William J. Cassel, Jr., M.D., M.P.H., Chief

###### HEALTH FACILITIES

Harold E. Josehart, M.S.H.A., Chief

Robert R. Cunningham, B.S., Special Assistant  
*Licensure and Certification Section*

Joseph I. Hutchinson, M.S.H.A., Coordinator  
Frank Moore, A.B., Standards Representative, Long-term Care Facilities

Agnes Burns, R.N., Nurse Consultant Supervisor

Donald G. Higgins, Medicare Program Representative

###### *Planning and Construction Section*

Aden H. Clump, M.A., Program Executive

William K. Ewing, B.S., Program Analyst  
*Rehabilitation Section*

Albert R. Siegel, M.D., Psychiatrist, Consultant in Physical Medicine and Rehabilitation (Part-time)

Janet Chermak, O.T.R., Supervisor of Rehabilitation Education Service

Reimbursable Costs—Robert J. McMahon

Packaged Disaster Hospital Program—Earl Murphy, B.A., USPHS

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Laboratory Evaluation—Robert G. Martinek, Pharm., D., Chief  
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Toxicology—Frank F. Fiorese, Ph.D., Chief  
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Springfield Diagnostic Laboratory  
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134 N. Ninth St., Springfield 62706  
Springfield Sanitary Bacteriology Laboratory  
Arnold Westerhold, B.S.,  
6th Floor Capitol Bldg., Springfield 62706  
Carbondale Laboratory  
Nathan Nagle, M.P.H.  
Oakland & Chautauqua Sts., Carbondale 62901  
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Vida B. Sloan, R.N., B.S., Consultant Nurse in Maternal and Child Health  
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Alvin B. Grant, B.S., Public Health Advisor, USPHS



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 Mt. Vernon State Tuberculosis Sanitarium—Robert J. Dancey, M.D., Medical Director and Superintendent  
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 Mary O'Donnell, R.N., Medical Self-Help Consultant  
 John Sturgeon, Emergency Health Representative

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**EAST CENTRAL REGION (II)**—Kenneth L. Baumann (Acting), 2125 S. First Street, Champaign 61820. Counties of Champaign, Clark, Coles, Kankakee, Macon, Cumberland, Edgar, Ford, and Moultrie and consultation to full-time

health departments of DeWitt-Piatt, Douglas, Effingham, Iroquois, Livingston, McLean, Shelby, Vermilion. **URBAN**—Champaign-Urbana Public Health District.

**NORTHWESTERN REGION (III)**—Arthur E. Sulek, M.D., M.I.H., 121 Fourth Ave., Rock Island 61201. Counties of Bureau, Henderson, Knox, Marshall, McDonough, Putnam, Stark, Tazewell, Warren, and Woodford and consultation to full-time health departments: Counties—Carroll, Fulton, Henry, Jo Daviess, Lee, Mercer, Ogle, Peoria, Rock Island, Stephenson, and Whiteside, City: Peoria.

**WEST CENTRAL REGION (IV)**—Evelyn M. Cunningham, R.N. (Acting), Room 173 State Regional Office Bldg., 601 Toronto Rd., Springfield 62706. Counties of Brown, Cass, Hancock, Logan, Macoupin, Mason, Sangamon, Schuyler, and Scott and consultation to full-time health departments: Counties—Adams, Calhoun, Christian, Greene, Jersey, Menard, Montgomery, Morgan, and Pike.

**SOUTH REGION (V)**—Elvin L. Sederlin, M.D., P.O. Box 722, Carbondale 62901. Counties of Hamilton and Perry and consultation to full-time health departments: Counties—Egyptian, (Gallatin-Saline-White), Franklin-Williamson, Jackson, Quadri-County, (Hardin-Johnson, Massac-Pope), Randolph, Tri-County (Alexander-Pulaski-Union).

**REGION (VI)**—E. E. Diddams, M.S.P.H. (Acting) 9500 Collinsville Rd., Unit E, Collinsville 62234. Counties of Clinton, Crawford, Edwards, Fayette, Jasper, Jefferson, Madison, Marion, Richland, St. Clair, Wabash, Washington, and Wayne and consultation to full-time health departments: Counties—Bond, Clay, Lawrence, and Monroe: Urban—East Side Health District (Canteen-Centreville-East St. Louis-Stites Township).

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 Bond County, Jane Greenwood, R.N., Acting Administrator, 100 N. Locust, Greenville 62246  
 Calhoun County, Mrs. Margaret Hillen, R.N., Acting Administrator, Hardin 62047  
 Carroll County, Acting Administrator (open), Mt. Carroll 61053  
 Christian County, Clara J. Beaty, R.N., Acting Administrator, 106 E. Main St., Taylorville 62568  
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 Cook County, John B. Hall, M.D., M.P.H., Director, 1425 S. Racine Ave., Chicago 60608  
 North District, 1755 Oakton St., Des Plaines 60018  
 South District, 51 E. 154 St., Harvey 60426  
 Southwest District, 5410 W. 95th St., Oak Lawn 60453

West District, 1907-09 Rice St., Melrose Park 60160  
 DeKalb County, Mrs. Audre Anderson, R.N., B.S., Acting Administrator 1731 Sycamore Rd., DeKalb 60115  
 DeWitt-Piatt Bi-County, Lelia V. Hyde, R.N., Acting Director, 122 E. Main St., Clinton 61727  
 Piatt County Office, Courthouse, Monticello 61856  
 Douglas County, Mary Lou Pflum, R.N., B.S.N., Acting Administrator, P.O. Box 382, Tuscola 61953  
 DuPage County, Charles A. Lang, M.D., M.P.H., Health Officer, 222 E. Willow Ave., Wheaton 60187  
 Effingham County, Peter C. Supan, M.D., M.P.H., Health Officer, 112 E. Section Ave., Effingham 62401

- Egyptian (Gallatin-Saline-White Counties) Allen Kelly, B.S., Acting Administrator, 1333 Locust St., Eldorado 62930  
White County, 208 N. Church, Carmi 62821  
Gallatin County, Courthouse, Shawneetown 62984
- Franklin-Williamson Bi-County, David P. Richerson, M.D., M.P.H., Health Officer, 217 E. Broadway, Johnston City 62951  
Franklin County, P.O. Box 461, 226 N. Main, Benton 62812
- Fulton County, Gordon J. Poquette, M.P.H., Public Health Administrator, 31 S. Main St., Canton 61520
- Greene County, Mrs. Barbara Cook, R.N., Acting Administrator, 229 N. Fifth St., Carrollton 62016
- Grundy County, Mrs. Mary C. Reed, R.N., Acting Administrator, Court House, Morris 60450
- Henry County, Grace Van Vooren, R.N., Acting Administrator, Court House Annex, Cambridge 61238
- Iroquois County, Miss Norma M. West, R.N., Acting Administrator, County Court House, Watseka 60970
- Jackson County, Mrs. Kathleen, B. Bahn, R.N., M.S., Acting Health Officer, 1015½ Chestnut St., Murphysboro 62966
- Jersey County, Mrs. Nola Kramer, R.N., Acting Administrator, Court House, P.O. Box 69, Jerseyville 62052
- Jo Daviess County, Marco Monti, M.P.H., Administrator, 311 S. Main St., Galena 61036
- Kendall County, Mrs. Mary Ann Klis, R.N., Acting Administrator, 203 Fox Rd., Yorkville 60560
- Lake County, Jack Irwin Smith, M.D., Dr. P.H., Acting Director, 1515 Washington St., Waukegan 60085  
Division of Nursing (Sub-Office), 330 N. Milwaukee Ave., Libertyville 60048
- Lawrence County, Maxine Jackman, R.N., Acting Director, Court House, Lawrenceville 62439
- Lee County, E. S. Parmenter, M.D., Health Officer, 316 W. Third St., Dixon 61021
- Livingston County, Mrs. Ann M. Lavin, R.N., Acting Administrator, Rm. 418, Bank of Pontiac Bldg., Pontiac 61764
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- McLean County, R. E. Baxter, M.D., Acting Medical Director, 401 W. Virginia Ave., Normal 61761
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- Mercer County, Mrs. Meba V. Keeseen, R.N., Acting Administrator, Court House, Aledo 61231
- Monroe County, Mrs. Edith Trost, R.N., Acting Administrator, 116 W. Mill St., Waterloo 62298
- Montgomery County, Willis L. Whitlock, Acting Health Officer, Box 149, Hillsboro 62049
- Morgan County, William D. Meyer, B.S., Acting Administrator, 234½ W. State St., Jacksonville 62650
- Ogle County, Sandra L. Greenfield, R.N., Acting Administrator, 106 S. Fifth St., Oregon 61061
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- Pike County, Mrs. Martha Lowry, R.N., Acting Administrator, 216 N. Monroe, Pittsfield 62362
- Quadri-County (Hardin-Johnson-Massac-Pope Counties), William Hensley, Acting Administrator, Box 437, Golconda 62938  
Massac County Office, Courthouse, P.O. Box 133, Metropolis 62960  
Johnson County Office, Vienna 62995  
Hardin County Office, Gross Bldg., Elizabethtown 62931
- Randolph County, Mrs. Marilyn Murphy, R.N., B.A., Acting Administrator, 110 W. Jackson St., Sparta 62286
- Rock Island County, John C. Schneider, Acting Administrator, Court House, Rock Island 61201
- Shelby County, Peter C. Supan, M.D., M.P.H., Health Officer, 123 N. Broadway, Shelbyville 62565
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- Tri-County (Alexander-Pulaski-Union Counties), Ralph K. Gibson, Administrator, 529 Cross St., P.O. Box 553, Cairo 62914  
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- Vermilion County, Mrs. Helen Armantrout, R.N., B.S., Acting Administrator, 808 N. Logan, Danville 61833
- Whiteside County, Mrs. Romona Stene, R.N., Acting Administrator, 201 W. First St., Rock Falls, 61071
- Will County, Herbert S. Miller, M.D., M.P.H., Health Officer, 14 West Jefferson St., Joliet 60431
- Winnebago County, Robert H. Anderson, Acting Health Officer, 425 W. State St., Rockford 61101

### Urban Health Departments

- Berwyn Health Department, Joseph L. Hrdina, M.D., Health Officer, 6600 W. 26th St., Berwyn, 60402
- Champaign—Urbana Public Health District, L. L. Fatherree, M.D., M.P.H., Public Health Director, 505 S. Fifth St., Champaign 61820

Chicago Board of Health, Morgan J. O'Connell, M.D., M.P.H., Commissioner of Health, Chicago Civic Center, Room 219, Chicago 60602  
 East Side Health District (Canteen-Centerville-East St. Louis-Sites Townships), John J. Gregowicz, M.D., Acting Public Health Director, 638 N. 20th St., East St. Louis 62205  
 Evanston-North Shore Health Department, Allan A. Filek, M.D., M.S.P.H., Public Health Director, Box 870, Evanston 60204  
 Hygienic Institute (LaSalle-Oglesby-Peru), Arlington Ailes, M.D., M.P.H., Director, LaSalle 61301  
 Oak Park Department of Public Health, Herbert Ratner, M.D., Public Health Director, Box 31, Oak Park 60303

Peoria Department of Health, Fred Long, M.D., M.P.H., Director of Health, 2116 N. Sheridan Rd., Peoria 61604

Rockford Department of Public Health, Arlo J. Anderson, B.S., Acting Commissioner of Health, City Hall Bldg., Rockford 61104

Skokie Health Department, Larry McElfresh, B.S., Acting Director of Health, 5127 Oakton St., Skokie 60076

Stickney Township Public Health District, Gene J. Franchi, D.D.S., M.P.H., Acting Public Health Director, 5635 State Rd., Oak Lawn 60459

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(Allied with Public Health Operations)

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### **Illinois Legislative Commission on Atomic Energy**

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(Allied with Public Health Operations)

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John B. Hall, M.D., Chicago  
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Marion B. McClelland, Decatur  
D. Bruce Hartley, Chicago  
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*Health Manpower*  
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*Personal Health Services*  
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*Financing of Health Services*  
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*Health Care Facilities*

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*Personal Health Services*

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*Personal Health Services*

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## Permanent Legislative Commissions

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## DEPARTMENT OF MENTAL HEALTH

401 S. Spring St., Springfield 62706

John F. Briggs, Acting Director  
 E. Kent Ayers, Administrative Assistant  
 Mortimer Brown, Ph.D., Assistant to the Director  
 H. Dickson Buckley, Legislative Liaison  
 Miss Roberta Egan, Administrative Assistant  
 Herman Heinecke, Administrative Assistant  
 James Walsh, Administrative Assistant  
 John B. Acheson, Special Assistant  
 (Medicare & Narcotics Programs)  
 Robert Lanier, Special Assistant  
 Margaret Schilling, Special Assistant  
 (Children's Programs)  
 William Lewis, Jr.  
 Robert Dahl, Public Information Officer  
 Jerome Goldberg, Special Counsel  
 Philip Arben, D.C.S., Management Consultant  
 Mrs. Jo Buchanan, Office Manager, Chicago  
 General Office

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Douglas Hadden, Administrator

### Division of Planning and Evaluation

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 and Evaluative Research  
 Joseph R. Godwin, Ph.D., Behavioral Scientist  
 Louis Rowitz, Research Sociologist  
 Mrs. Mary Grossberg, Communications Specialist

### Division of Mental Retardation Services

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Lawrence Bussard, Assistant Division Director  
 (Administration)  
 Charles Jubenville, Ed.D., Assistant Division  
 Director (Extra-Mural Programs)  
 Richard Scheerenberger, Ph.D., Assistant Division  
 Director (Prog. Coordination)  
 Ralph Wagner, Assistant Project Coordinator  
 Christian Simonson, Day Care Consultant  
 Thomas Villiger, Administrator, Individual Care  
 Grants & Waiting List  
 Mrs. Ruth Bartle, Private Care Consultant  
**Institutions for Mentally Retarded**  
 A. L. BOWEN CHILDREN'S CENTER, A. J. Shafter,  
 Ph.D., Superintendent  
 DIXON STATE SCHOOL, David Edelson, Superintend-  
 ent  
 WILLIAM W. FOX CHILDREN'S CENTER, Thomas P.  
 Crane, M.D., Superintendent  
 LINCOLN STATE SCHOOL, Louis Belinson, M.D.,  
 Superintendent  
 WARREN G. MURRAY CHILDREN'S CENTER, Fred  
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### Division of Professional Services

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 Mrs. Annette Calloway, Chief, Psychiatric Social  
 Services  
 Paul F. Cole, R.Ph., Supervising Pharmacist  
 Ira D. Cravens, Chief, Veterans Services  
 A. A. Kaluzny, M.D., Medical Services  
 C. P. Macaluso, Chief, Clinical Laboratories  
 Mrs. Louise A. Meyer, R.N., Assistant Chief,  
 Nursing Services  
 Jack Saporta, Ph.D., Assistant Chief, Psychology  
 Services  
 Miss Jane Phillips, Chief, Volunteer Services

Rudyard Propst, Chief, Rehabilitation Services  
Paul A. Rittmanic, Ph.D., Chief, Speech and  
Hearing Services  
Lyman Samo, Chief, Special Education Services

### **Division of Comprehensive Mental Health Services**

Thomas T. Tourlentes, M.D., Acting Division  
Director

#### **Zones and Institutions**

ROCKFORD: Donald W. Hart, Acting Zone  
Director, H. Douglas Singer Zone Center, 4402  
N. Main St., Rockford 61103

H. DOUGLAS SINGER ZONE CENTER:  
William G. Smith, M.D., Superintendent

CHICAGO AREA ZONE: Patrick Staunton,  
M.D., Director, 160 N. LaSalle St., Chicago  
60601

CHARLES F. READ: Chicago State Hos-  
pital, 6500 W. Irving Park Rd., Chicago  
60634

CHICAGO STATE HOSPITAL: Francois  
Alouf, M.D., Superintendent, 6500 W. Irving  
Park Rd., Chicago 60634

MENTAL HEALTH CENTER: Francois  
Alouf, M.D., (responsible for administra-  
tion) 2449 W. Washington Blvd., Chicago  
60612

JOHN J. MADDEN ZONE CENTER: Rob-  
ert DeVito, M.D., Superintendent, 1200 S.  
First Ave., Hines 60141

ELGIN STATE HOSPITAL: Daniel A. Ma-  
nelli, M.D., Acting Superintendent, Elgin  
60120

MANTENO STATE HOSPITAL: H. C.  
Piepenbrink, Superintendent, Manteno 60950

TINLEY PARK MENTAL HEALTH CEN-  
TER: H. C. Piepenbrink, Acting Superin-  
tendent, Tinley Park 60477

PEORIA: Thomas T. Tourlentes, M.D., Zone Di-  
rector, George A. Zeller Zone Center, Peoria  
61614 (address mail to Galesburg State Re-  
search Hospital, Galesburg 61401)

GEORGE A. ZELLER ZONE CENTER:  
James Ward, M.D., Superintendent, 5407 N.  
University, Peoria 61614

EAST MOLINE STATE HOSPITAL: Kon-  
stantin Dimitri, M.D., Superintendent, East  
Moline 61244

GALESBURG STATE RESEARCH HOSPI-  
TAL: Thomas T. Tourlentes, M.D., Super-  
intendent, Galesburg 61401

PEORIA STATE HOSPITAL: Henry D.  
Staras, M.D., Superintendent, Peoria 61607

SPRINGFIELD: Charles E. Beck, M.D., Zone  
Director, Andrew McFarland Zone Center,  
Springfield 62707

ANDREW MCFARLAND ZONE CENTER:  
Martin Cohen, Ph.D., Superintendent, 600  
Toronto Rd., Springfield 62707

JACKSONVILLE STATE HOSPITAL: Steve  
Pratt, Ph.D., Superintendent, Jacksonville  
62650

DECATUR-CHAMPAIGN: Lewis Kurke, M.D.,  
Zone Director, Adolf Meyer Zone Center, De-  
catur 62526

ADOLF MEYER ZONE CENTER (Adults):  
Lewis Kurke, M.D., Acting Superintendent,  
East Mound Rd., Decatur 62526

HERMAN M. ADLER ZONE CENTER  
(Children): J. Gregory Langan, Ed.D., Su-  
perintendent, 2204 Griffith Dr., Champaign  
61820

ZONE VII (East St. Louis): Ivan Pavkovic, M.D.,  
Director Zone Office: 4500 College Avenue,  
Alton 62002

ZONE VIII (Carbondale): Robert C. Steck,  
M.D., Zone Director, Anna 62906

ANNA STATE HOSPITAL: Robert C. Steck,  
M.D., Superintendent, Anna 62906

ILLINOIS SECURITY HOSPITAL: Vernon  
J. Uffelman, Superintendent, Chester 62233

#### **Community Services**

Charles R. Meeker, Chief  
B. W. Tucker, Chief, Mental Health Education  
Joseph B. Lehmann, Consultant, Community  
Mental Health Clinics  
Muriel Rietz, Chief, Interstate Services

#### **Alcoholism Programs**

Richard S. Cook, M.D., Chief  
William N. Becker, Jr., Assistant Chief

#### **Medical Center Complex**

Lester H. Rudy, M.D., Director, Medical Center  
Complex

#### **Institute for Juvenile Research**

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#### **Illinois State Pediatric Institute**

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#### **Illinois State Psychiatric Institute**

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#### **Division of Research Services**

Noel Jenkin, Ph.D., Acting Division Director

#### **Field Division, Mental Health, Department of Personnel**

John Meyer, Acting Chief Personnel Officer



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C. R. Crawford, Division Director  
Budgetary Services  
Fiscal Services  
Accounting & Audits  
Mental Health Fund Programs

## **Division of General Services**

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Joseph L. McGrath, Deputy Director, Physical  
Plant Services  
Frank F. Campbell, Deputy Director, Administra-  
tive Services  
Reimbursement Services

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Willard King, Chicago  
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John Adam Zvetina, Chicago  
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Mrs. L. Trimble Steinbrecher, Chicago, Execu-  
tive Secretary

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Harold Meitus, Chicago

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Senator Harris W. Fawell, Naperville  
Paul Fromm, Chicago  
Commissioner Lewis Hill, Chicago  
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LeRoy Levitt, M.D., Chicago  
Robert S. Mendelsohn, M.D., Evanston  
Senator Esther Saperstein, Chicago  
Representative Anthony Scariano, Chicago Heights  
Representative Arthur Telcser, Chicago  
(2 Vacancies)  
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James Holland, Chairman, Board of Mental  
Health Commissioners; Robert L. McFarland,  
Ph.D., Chicago; Director of Mental Health; A.  
Bond Woodruff, Ph.D., DeKalb  
Mrs. Paulette K. Hartrich, Chicago, Executive  
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Dan Morse, M.D., Peoria  
Darrell H. Trumpe, M.D., Springfield  
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(1 Vacancy)

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of Mental Health

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David P. Richerson, M.D., Johnston City  
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## **DEPARTMENT OF CHILDREN AND FAMILY SERVICES**

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Room 404, New State Office Bldg.  
 Springfield  
 Room 1713, 160 N. LaSalle St.  
 Chicago  
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 Roman L. Haremski, Deputy Director  
 Richard S. Laymon, Administrative Asst. to Director  
 J. Keller Mack, M.D., Medical and Public Health Officer  
 Philip D. Wynn, Special Counsel  
 Don H. Schlosser, Administrator of Community Relations

### **Division of Administrative Services:**

Matthew J. Finnell, Division Chief  
 Room 404, New State Office Bldg., Springfield

### **Division of Child Welfare:**

528 S. Fifth St., Springfield  
 Roman L. Haremski, Acting Director  
 Herschel L. Allen, Chief of Program Services  
 Merle E. Springer, Chief of Metropolitan Operations  
 Ralph L. Hanebutt, Chief of Downstate Operations

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 Rockford District, 428 Seventh St., Rockford  
 Ottawa District, 628 Columbus St., Ottawa  
 Rock Falls District, 203½ First Ave., Rock Falls

**CHICAGO REGION** (Ralph Baur, Reg. Dir.)  
 1026 S. Damen, Chicago  
 East District, 2030 S. Michigan, Chicago  
 Herrick House Children's Center, W. Bartlett Rd., Bartlett  
 Lawndale Day Care Center, 2929 W. 19th, Chicago

**AURORA REGION** (Leland Wright, Reg. Dir.),  
 361 Old Indian Trail, Aurora  
 Aurora District, 361 Old Indian Trail, Aurora  
 Joliet District, 57 W. Jefferson, Joliet  
 Waukegan District, 4 S. Genesee, Waukegan

**PEORIA REGION** (Francis Paule, Reg. Dir.),  
 608 N. E. Jefferson, Peoria  
 Peoria District, 414 Hamilton Blvd., Peoria  
 Galesburg District, 121 S. Prairie, Galesburg  
 Moline District, 1805 Seventh St., Moline  
 Princeton District, 22 E. Marion, Princeton

**SPRINGFIELD REGION** (Wm. Sanders, Reg. Dir.), 601 Toronto Rd., Springfield  
 Springfield District, State Regional Office Building, 601 Toronto Rd., Springfield  
 Quincy District, 410 N. Ninth, Quincy  
 Carlinville District, 494½ West Side Square, Carlinville  
 Jacksonville District, 602 Westgate, Jacksonville

**CHAMPAIGN REGION** (Ralph L. Hanebutt, Acting Reg. Dir.), 2125 S. First St., Champaign  
 Champaign District, 2125 S. First St., Champaign  
 Bloomington District, 309 W. Market, Bloomington

Decatur District, 125 N. Franklin,  
Decatur  
Kankakee District, 70 Meadowview  
Center, Kankakee  
Mattoon District, 1000 Broadway, Mattoon  
MURPHYSBORO REGION (Paul Nelson, Reg.  
Dir.), 9 South 12th Street, Murphysboro  
Murphysboro District, 21 N. 11th St.,  
Murphysboro  
Harrisburg District, 10 Vine St., Harris-  
burg  
EAST ST. LOUIS REGION (Jack Donahue, Reg.  
Dir.), 310 N. Tenth, East St. Louis  
East St. Louis District, 917 Illinois Avenue  
East St. Louis  
Olney District, 1108 S. West St., Olney  
Salem District, 205 E. Locust, Salem

### Division of Children's Schools:

Lee A. Iverson, Division Chief  
Room 404, New State Office Bldg., Springfield

#### Institutions—

Illinois Braille and Sight Saving School  
(Jack Hartong, Supt.), Jacksonville  
Illinois School for the Deaf (Kenneth  
Mangan, Supt.), Jacksonville  
Illinois Children's Hospital-School (Paul  
Kavanaugh, Supt.) 1950 W. Roosevelt Rd.,  
Chicago  
Illinois Soldiers' and Sailors' Children's  
School, (Andrew Spelios, Supt.), Normal  
Southern Illinois Children's Service Center  
(Paul Nelson, Supt.), Hurst

### Division of Personnel Administration:

Thomas A. Nickell, Division Chief  
Room 404, New State Office Bldg., Springfield

### Division of Planning, Research and Statistics:

William H. Ireland, Division Chief  
630 E. Adams St., Springfield

### Division of Rehabilitation Services:

Charles Adams, Division Chief  
Room 404, New State Office Bldg., Springfield

#### Institutions—

Illinois Eye and Ear Infirmary (George  
Geocariss, Supt.), 1855 Taylor, Chicago  
Illinois Soldiers' and Sailors' Home (Richard  
Northern, Supt.) Quincy  
Illinois Visually Handicapped Institute  
(Thomas Murphy, Supt.) 1151 S. Wood  
St., Chicago

#### Visually Handicapped Services—

Community Services for the Visually Handi-  
capped (I. N. Miller, Supt.), Room 1700,  
160 N. LaSalle St., Chicago  
(field offices located in each regional office  
—see listings under Division of Child  
Welfare)  
Coordinator of Visually Handicapped Services  
(Raymond M. Dickinson), 404 New State  
Office Bldg., Springfield

## DEPARTMENT OF PUBLIC AID

The Illinois Department of Public Aid admin-  
isters the federally aided public assistance pro-  
grams: Assistance to the Aged, Blind or Disabled;  
Aid to Dependent Children; and Medical Assist-  
ance. In addition, the department allocates state  
funds to qualified governmental units for the ad-  
ministration of General Assistance; and in co-  
operation with the United States Department of  
Agriculture, administers the Food Stamp program.

### Administrative Staff

Harold O. Swank, Director  
Gershon Hurwitz, Deputy Director  
Robert L. Hyde, Chief, Division of Accounting  
and Data Processing  
Garrett W. Keaster, Chief, Division of  
Administrative Services  
Henry L. McCarthy, Chief, Division of  
Community Services  
James M. Brown, Chief, Division of  
Downstate Operations  
Henry A. Holle, M.D., Medical Director,  
Division of Medical Services

Robert G. Wessel, Chief, Medical Administration  
Mrs. Janet P. Kahlert, Chief, Division of  
Program Development  
Wayne D. Epperson, Chief, Division of  
Research and Statistics  
Richard N. Hosteny, Chief, Division of  
Special Investigations  
Kenneth E. Doebelin, Chief, Division of  
Special Services

### Regional Offices

Region I —Peoria	Frank G. Blumb, Regional Director
Region II —Champaign	C. H. Colwell, Regional Director
Region III—Springfield	Robert A. Hamrick, Regional Director
Region IV—Belleville	Armin A. Rippelmeyer, Regional Director
Region V —Carbondale	Lawrence E. Duff, Regional Director
Region VI—Rockford	Reno L. Lenz, Regional Director



### **Legislative Advisory Committee on Public Assistance**

The Honorable Merle K. Anderson, Durand  
The Honorable Meade Baltz, Joliet  
The Honorable Charles M. Campbell, Danville  
The Honorable John W. Carroll, Park Ridge  
The Honorable Corneal A. Davis, Chicago  
The Honorable Daniel Dougherty, Chicago  
The Honorable Walter P. Hoffelder, Chicago  
The Honorable James G. Krause, East St. Louis  
The Honorable Robert E. Mann, Chicago  
The Honorable Don A. Moore, Midlothian  
The Honorable Esther Saperstein, Chicago  
The Honorable Fred J. Smith, Chicago

### **Board of Public Aid Commissioners**

Charles A. Davis, Chicago  
Robert G. Gibson, Chicago  
Robert H. MacRae, Chicago  
Chauncey C. Maher, Jr., M.D., Springfield  
Mrs. Woods McCausland, Winnetka  
Thomas A. Nieman, Rockford  
Robert W. Weissmiller, Mount Carroll

### **Medical Care Advisory Committee**

Murray H. Finley, Chicago  
Mrs. Mary L. Ford, Chicago  
Vernon J. Hass, D.D.S., Bloomington  
Mrs. Jeannette Kramer, Palatine  
Chauncey C. Maher, Jr., M.D., Springfield  
B. E. Montgomery, M.D., Harrisburg  
Robert C. Muehrcke, M.D., Oak Park  
Frank McCallister, Chicago  
Harold W. Pratt, R.Ph., Chicago

### **Ex-Officio members**

John F. Briggs, Acting Director,  
Department of Mental Health, Springfield  
Edward F. Lis, M.D., Director,  
Division of Services for Crippled Children  
University of Illinois, Chicago  
Alfred Slicer, Director,  
Division of Vocational Rehabilitation, Springfield  
Edward T. Weaver, Director,  
Department of Children and Family Services,  
Springfield  
Franklin D. Yoder, M.D., M.P.H., Director,  
Department of Public Health, Springfield

### **Department of Public Aid Representative**

Henry A. Holle, M.D., Medical Director,  
Division of Medical Services,  
Department of Public Aid, Springfield

### **State Medical Advisory Committee**

Louis Arp, Jr., M.D., Moline  
Charles E. Baldree, M.D., Belleville  
James R. Cooper, M.D., Quincy  
Earl E. Fredrick, Jr., M.D., Chicago  
LeBaron P. Johnson, M.D., Rockford  
Paul F. LaFata, M.D., Springfield  
George F. Lull, M.D., Chicago  
Rex O. McMorris, M.D., Peoria  
George T. Mitchell, M.D., Marshall  
Robert C. Muehrcke, M.D., Oak Park  
Alphonse L. Robinson, M.D., Mounds  
John H. Steinkamp, M.D., Belvidere  
R. Kent Swedlund, M.D., Watseka  
Fred A. Tworoger, M.D., Chicago

### **State Drug Advisory Committee**

Miles N. Brown, R.Ph., Mount Vernon  
W. Edwin Brown, R.Ph., Quincy  
Carl V. Daschka, R.Ph., Chester  
H. M. F. Doden, Sr., R.Ph., Rock Island  
Justin Eisele, R.Ph., East St. Louis  
Louis Gdalmann, R.Ph., Chicago  
John T. Gulick, R.Ph., Danville  
John F. Koller, R.Ph., Berwyn  
Roy B. Maher, R.Ph., Springfield  
Harold W. Pratt, R.Ph., Chicago  
Theodore R. Sherrod, R.Ph., M.D., Chicago  
Harold J. Shinnick, R.Ph., Chicago  
Charles P. Skaggs, R.Ph., Harrisburg

### **State Dental Advisory Committee**

John C. Barrett, D.D.S., Freeport  
John J. Byrne, D.D.S., Chicago  
John C. Clarno, D.D.S., Peoria  
Vernon J. Haas, D.D.S., Bloomington  
Lewis K. Holzman, D.D.S., Chicago  
Eugene J. Jaffe, D.D.S., Chicago  
D. J. McCullough, D.D.S., Mt. Vernon  
H. B. Riley, D.D.S., Newton  
William J. Rogers, D.D.S., Chicago  
Carl L. Sebelius, D.D.S., M.P.H., Springfield  
Harold H. Sitron, D.D.S., Chicago

### **State Advisory Committee on Group Care Facilities**

Don T. Barry, Raymond  
Taylor O. Braswell, Belleville  
Edward Cannady, M.D., East St. Louis  
Bert Cohn, Okawville  
Mrs. Rachel Dodson, Herrin  
Markham D. Hay, Rockford  
Mrs. Bernice Hover, Chicago  
Elmer Johnson, Joliet  
Mrs. Laverta Johnson, Chicago  
Mrs. Jeannette Kramer, Palatine  
Robert E. Lanier, Springfield  
Roger F. Sondag, M.D., M.P.H., Springfield

## DIVISION OF VOCATIONAL REHABILITATION

The Board of Vocational Education and Rehabilitation is a statutory body, established to administer, through two operating divisions, the state program of vocational and technical edu-

cation pursuant to the Federal Vocational Education Act as amended, and the state program of vocational rehabilitation pursuant to the Federal Vocational Rehabilitation Act as amended.

### Board of Vocational Education and Rehabilitation

#### Ex Officio:

Director of Agriculture  
Director of Labor  
Director of Mental Health  
Director of Public Health  
Director of Registration and Education  
Superintendent of Public Instruction

#### Appointive Members (appointed by Governor):

Helen Schmid, Glen Ellyn  
James D. Broman, Chicago  
Robert Friedlander, Chicago  
William Gellman, Ph.D., Chicago  
Edward T. Scholl, Chicago  
Rosetta Wheadon, Ph.D., East St. Louis

#### Executive Officers:

For vocational education: Ray Page,  
Superintendent of Public Instruction  
For vocational rehabilitation: Alfred Slicer  
Director, Division of Vocational Rehabilitation

#### Division of Vocational Rehabilitation

Alfred Slicer, Director  
623 East Adams, Springfield 62706

#### Division of Vocational and Technical Education

Sherwood Dees, Acting Director  
405 Centennial Building, Springfield 62706

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## HOSPITALS

The Illinois Department of Public Health is responsible for implementing the Hospital Licensing Act, excerpts from which follows:

Section 2. The purpose of this Act is to provide for the better protection of the public health through the development, establishment, and enforcement of standards (1) for the care of individuals in hospitals, (2) for the construction, maintenance, and operation of hospitals which, in light of advancing knowledge, will promote safe and adequate treatment of such individuals in hospitals, and (3) that will have regard to the necessity of determining that a person establishing a hospital have the qualifications, background, character and financial resources to adequately provide a proper standard of hospital service for the community.

#### Hospital Licensing Requirements

To implement the Hospital Licensing Act, the Department of Public Health has patient requirements. The following cover the medical staff.

1. The medical staff shall be composed only of physicians and dentists licensed by the Illinois Department of Registration and Education in accordance, respectively, with provisions of the Medical Practice Act and Dental Practice Act.

2. The medical staff shall be organized in accordance with written bylaws, rules and regulations, approved by the governing board. The bylaws, rules and regulations shall specifically provide:

- a. for eligibility for staff membership;
- b. for such divisions and departments as are warranted, (as a minimum, Active and Consulting divisions are required)
- c. for such officers and/or committees as are warranted; however, committees shall be designed to be responsible for medical records and for pharmacy and therapeutics;
- d. for determination of qualifications and privileges;
- e. that medical staff meetings be held regularly, and that written minutes of all meetings be kept;
- f. for review and analysis of the clinical experience of the hospital at regular intervals—the medical records of patients to be the basis for such review and analysis;
- g. that tissue removed at operation shall be examined by a qualified pathologist and that the findings shall be made a part of the patient's medical record;
- h. for consultation between medical staff members in complicated cases; and
- i. for keeping complete medical records.

#### Section B. Supervision of Patient Care

All persons admitted to the hospital shall be under the professional care of a member of the medical staff.

#### Section C. Orders for Medication and Treatment

No medication or treatment shall be given to a patient except on the written order of a member of the medical staff.

## Section D. Tissue Examination

All tissue removed at operation shall be examined by a qualified pathologist and the findings shall be made a part of the patient's hospital medical record. A tissue committee of the medi-

cal staff is highly recommended.

The governing board shall provide that one or more physicians shall be available at all times for emergencies.

## Identification of Hospitals

\*The hospitals marked with an asterisk (\*) are those which are accredited by the Joint Commission on Accreditation of Hospitals as of Aug. 1, 1969.

The presence of a hospital on this list means it has complied in the main with the standards of the Joint Commission on Accreditation of Hospitals as compiled over the years by the medical and hospital professions. The standards are minimal and it is hoped hospitals will make every effort to exceed them.

Hospitals with less than 25 beds are not eligible for accreditation.

Accredited hospitals with a functioning utilization review plan are eligible providers of service under Medicare. Hospitals ineligible for accreditation or unable to meet JCAH requirements have been especially surveyed by the Illinois Department of Public Health and virtually all have been certified as eligible providers of service under Medicare.

Inquires about this listing or hospital accreditation should be directed to the office of the

Joint Commission on Accreditation of Hospitals at 645 N. Michigan Ave., Chicago 60611.

\*\*Double asterisk: approved to admit selected gynecological patients to maternity departments.

†Dagger indicates general hospitals having psychiatric units licensed by the Illinois Department of Public Health. All other mental facilities are licensed and/or operated by this department (federal hospitals excluded).

Number in parenthesis indicates number of beds in hospital. Initial preceding number refers to the type of control, as follows:

A—Corporation

B—Non-profit association or corporation

C—Privately owned and operated

D—City

E—County

F—Hospital District

G—Sanitarium District

H—Township

I—State

J—Federal

## GENERAL HOSPITALS

### ALEDO (Mercer)

\*Mercer County Hospital (E-55)

### ALTON (Madison)

\*\*Alton Memorial Hospital (B-212)

\*St. Anthony's Hospital (B-140)

\*\*St. Joseph's Hospital (B-152)

### AMBOY (Lee)

Amboy Public Hospital (B-15)

### ANNA (Union)

\*Union County Hospital District (F-48)

### ARLINGTON HEIGHTS (Cook)

\*\*Northwest Community Hospital (B-223)

### AURORA (Kane)

\*\*Copley Memorial Hospital (B-200)

\*St. Charles Hospital (B-110)

\*\*St. Joseph Mercy Hospital (B-107)

### AVON (Warren)

Saunders Hospital (B-24)

### BEARDSTOWN (Cass)

\*Schmitt Memorial Hospital (D-50)

### BELLEVILLE (St. Clair)

\*\*Memorial Hospital (B-231)

†\*\*St. Elizabeth's Hospital (B-333)

### BELVIDERE (Boone)

\*Highland Hospital, Inc. (B-30)

\*St. Joseph's Hospital (B-100)

### BENTON (Franklin)

\*The Franklin Hospital (F-125)

### BERWYN (Cook)

†\*\*MacNeal Memorial Hospital (B-419)

### BLOOMINGTON (McLean)

\*Mennonite Hospital (B-130)

\*St. Joseph's Hospital (B-158)

### BLUE ISLAND (Cook)

\*\*St. Francis Hospital (B-220)

### BREESE (Clinton)

\*St. Joseph's Hospital (B-42)

### CAIRO (Alexander)

\*St. Mary's Hospital (B-130)

### CANTON (Fulton)

\*Graham Hospital Association (B-152)

### CARBONDALE (Jackson)

\*Doctors Memorial Hospital (B-67)

\*Holden Hospital (B-58)

### CARLINVILLE (Macoupin)

\*Carlinville Area Hospital (B-68)

### CARMI (White)

\*Carmi Township Hospital (H-63)

### CARROLLTON (Greene)

Thomas H. Boyd Memorial Hospital (B-43)

### CARTHAGE (Hancock)

\*Memorial Hospital (B-80)

### CASEYVILLE (St. Clair)

Pleasant View Sanitorium (E-70)

### CENTRALIA (Marion)

\*\*St. Mary's Hospital (B-121)



- CHAMPAIGN (Champaign)  
 \*\*Burnham City Hospital (D-111)  
 \*Cole Hospital (C-61)
- CHARLESTON (Coles)  
 \*Charleston Community Memorial Hospital, Inc., (B-65)
- CHESTER (Randolph)  
 \*Memorial Hospital (F-52)
- CHICAGO (Cook)  
 \*American Hospital of Chicago (B-168)  
 \*\*Augustana Hospital (B-350)  
 \*\*Belmont Community Hospital (B-151)  
 \*Bethany Brethren Hospital (B-57)  
 \*Bethany Methodist Hospital (B-194)  
 \*Bethesda Hospital (B-147)  
 \*Booth Memorial Hospital (B-19)  
 \*Central Community Hospital (B-93)  
 \*Cermak Memorial Hospital (D-129)  
 \*Schwab Rehabilitation Hospital (B-61)  
 \*Chicago Eye, Ear, Nose and Throat Hospital (C-37)  
 \*Chicago Osteopathic Hospital (B-171)  
 \*Chicago State Tuberculosis Sanitarium (I-336)  
 †\*\*Chicago Wesley Memorial Hospital (B-651)  
 \*Children's Memorial Hospital (B-236)  
 \*Columbus Hospital (B-407)  
 \*Cook County Hospital (E-2,747)  
 \*Edgewater Hospital (B-389)  
 \*\*Englewood Hospital (B-169)  
 \*Evangelical Hospital of Chicago (B-174)  
 \*Forkosh Memorial Hospital (B-150)  
 \*\*Frank Cuneo Hospital (B-171)  
 \*Franklin Boulevard Community Hospital (B-110)  
 \*Garfield Park Community Hospital (B-134)  
 †\*\*Grant Hospital of Chicago (B-339)  
 Halco Hospital, Inc. (C-10)  
 Henrotin Hospital (B-104)  
 \*\*Holy Cross Hospital (B-384)  
 \*Hospital of St. Anthony de Padua (B-209)  
 \*Illinois Central Hospital (B-299)  
 †\*\*Illinois Masonic Medical Center (B-544)  
 \*Jackson Park Hospital Foundation (B-182)  
 \*LaRabida Jackson Park Sanitarium (B-104)  
 †\*Loretto Hospital (B-163)  
 \*Louis A. Weiss Memorial Hospital (B-250)  
 \*Louis Burg Hospital (B-100)  
 \*Martha Washington Hospital (B-58)  
 \*\*Mary Thompson Hospital (B-112)  
 †\*\*Mercy Hospital (B-355)  
 †\*\*Michael Reese Hospital and Medical Center (B-933)  
 †\*\*Mount Sinai Hospital Medical Center of Chicago (B-374)  
 \*Municipal Contagious Disease Hospital (D-100)  
 \*Municipal Tuberculosis Sanitarium (D-1,000)  
 Northeast Community Hospital (B-137)  
 Northwest Hospital, Inc. (C-225)  
 \*\*Norwegian-American Hospital, Inc. (B-222)
- †\*\*Passavant Memorial Hospital (B-364)  
 †\*\*Presbyterian-St. Luke's Hospital (B-838)  
 \*Provident Hospital and Training School (B-204)  
 \*\*Ravenswood Hospital Medical Center (B-282)  
 \*Rehabilitation Institute of Chicago (B-65)  
 \*\*Resurrection Hospital (B-265)  
 \*Roosevelt Memorial Hospital (B-125)  
 \*Roseland Community Hospital (B-120)  
 \*\*St. Anne's Hospital (B-436)  
 \*St. Bernard's Hospital (B-197)  
 \*St. Elizabeth's Hospital (B-336)  
 \*\*St. Frances Xavier Cabrini Hospital (B-209)  
 \*St. George Hospital (B-122)  
 †\*\*St. Joseph Hospital (B-488)  
 \*St. Mary of Nazareth Hospital (B-285)  
 St. Vincent's Infant Hospital (B-65)  
 \*Shriners Hospital for Crippled Children (Chicago Unit) (B-68)  
 \*\*South Chicago Community Hospital (B-300)  
 \*\*South Shore Hospital (B-189)  
 \*\*Swedish Covenant Hospital (B-236)  
 †\*\*University of Chicago Hospitals and Clinics (B-675)  
 †University of Illinois Research and Educational Hospitals (I-599)  
 \*The von Solbrig Memorial Hospital, Inc. (A-97)  
 \*Walther Memorial Hospital (B-220)  
 \*\*Woodlawn Hospital (B-143)
- CHICAGO HEIGHTS (Cook)  
 \*\*St. James Hospital (B-411)
- CHRISTOPHER (Franklin)  
 \*The Miners Hospital (B-34)
- CLIFTON (Iroquois)  
 Central Hospital (B-36)
- CLINTON (DeWitt)  
 \*John Warner Hospital (D-47)
- DANVILLE (Vermilion)  
 \*\*Lake View Memorial Hospital (B-231)  
 \*\*St. Elizabeth Hospital (B-182)
- DECATUR (Macon)  
 \*\*Decatur Memorial Hospital (B-337)  
 \*Macon County Tuberculosis Sanitarium (E-41)  
 \*St. Mary's Hospital (B-389)  
 \*The Wabash Memorial Hospital (B-61)
- DeKALB (DeKalb)  
 \*DeKalb Public Hospital (D-91)
- DES PLAINES (Cook)  
 \*\*Holy Family Hospital (B-248)
- DIXON (Lee)  
 \*Dixon Public Hospital (B-138)
- DU QUOIN (Perry)  
 \*Marshall Browning Hospital (B-66)
- EAST ST. LOUIS (St. Clair)  
 \*Centreville Township Hospital (H-153)  
 \*\*Christian Welfare Hospital (B-279)  
 \*\*St. Mary's Hospital (B-312)
- EFFINGHAM (Effingham)  
 \*St. Anthony Memorial Hospital (B-140)

ELDORADO (Saline)  
     Ferrell Hospital (C-48)  
     \*Pearce Hospital Foundation (B-48)  
 ELGIN (Kane)  
     \*\*St. Joseph Hospital (B-154)  
     \*\*Sherman Hospital Association (B-335)  
 ELK GROVE VILLAGE (Cook)  
     \*\*St. Alexius Hospital (B-198)  
 ELMHURST (DuPage)  
     \*\*Memorial Hospital of DuPage County (B-451)  
 EUREKA (Woodford)  
     \*Eureka Hospital (C-35)  
 EVANSTON (Cook)  
     \*Community Hospital of Evanston (B-54)  
     †\*\*Evanston Hospital Association (B-463)  
     \*Northwestern University Student Health Service Hospital (B-44)  
     \*\*St. Francis Hospital (B-520)  
 EVERGREEN PARK (Cook)  
     †\*\*Little Company of Mary Hospital (B-566)  
 FAIRBURY (Livingston)  
     \*Fairbury Hospital (B-87)  
 FAIRFIELD (Wayne)  
     \*Fairfield Memorial Hospital (B-104)  
 FLORA (Clay)  
     \*Clay County Hospital (E-50)  
 FREEPORT (Stephenson)  
     \*\*Freeport Memorial Hospital (B-245)  
 GALENA (Jo Daviess)  
     \*The Galena Hospital District (F-31)  
 GALESBURG (Knox)  
     \*\*Galesburg Cottage Hospital (B-202)  
     \*St. Mary's Hospital (B-134)  
 GENESEO (Henry)  
     \*Hammond-Henry District Hospital (F-91)  
 GENEVA (Kane)  
     \*\*Community Hospital (B-115)  
 GIBSON CITY (Ford)  
     \*Gibson Community Hospital (B-59)  
 GRANITE CITY (Madison)  
     \*\*St. Elizabeth Hospital (B-256)  
 GREENEVILLE (Bond)  
     \*Edward A. Utlaut Memorial Hospital (B-72)  
 HARRISBURG (Saline)  
     \*Doctors Hospital of Harrisburg, Inc. (C-80)  
 HARVARD (McHenry)  
     \*Harvard Community Memorial Hospital (F-40)  
 HARVEY (Cook)  
     \*Ingalls Memorial Hospital (B-334)  
 HAVANA (Mason)  
     \*Mason District Hospital (F-64)  
 HAZEL CREST (Cook)  
     \*South Suburban Hospital Foundation (B-56)  
 HERRIN (Williamson)  
     \*Herrin Hospital (B-111)  
 HIGHLAND (Madison)  
     \*\*St. Joseph's Hospital (B-133)  
 HIGHLAND PARK (Lake)  
     \*\*The Highland Park Hospital Foundation (B-196)  
 HILLSBORO (Montgomery)  
     \*Hillsboro Hospital (B-80)  
 HINSDALE (Cook)  
     \*The Suburban Cook County Tuberculosis Sanitarium District (G-206)  
 HINSDALE (DuPage)  
     †\*\*Hinsdale Sanitarium and Hospital (B-360)  
 HOOPESTON (Vermilion)  
     \*Hoopestown Community Memorial Hospital (B-44)  
 HOPEDALE (Tazewell)  
     \*Hopedale Hospital (B-82)  
 JACKSONVILLE (Morgan)  
     \*Frank A. Norris Hospital (B-142)  
     \*Passavant Memorial Area Hospital (B-152)  
 JERSEYVILLE (Jersey)  
     \*Jersey Community Hospital (F-54)  
 JOLIET (Will)  
     †\*\*St. Joseph Hospital (B-444)  
     \*Silver Cross Hospital (B-281)  
     \*Sunny Hill Sanatorium (E-41)  
 KANKAKEE (Kankakee)  
     \*Riverside Hospital (B-189)  
     \*St. Mary's Hospital (B-257)  
 KEWANEE (Henry)  
     \*Kewanee Public Hospital Association (B-74)  
 LA GRANGE (Cook)  
     \*\*Community Memorial General Hospital (B-220)  
 LA HARPE (Hancock)  
     LaHarpe Hospital (B-25)  
 LAKE FOREST (Lake)  
     \*\*Lake Forest Hospital (B-113)  
 LASALLE (LaSalle)  
     \*St. Mary's Hospital (B-148)  
 LAWRENCEVILLE (Lawrence)  
     \*Lawrence County Memorial Hospital (E-64)  
 LIBERTYVILLE (Lake)  
     \*\*Condell Memorial Hospital (B-91)  
 LINCOLN (Logan)  
     \*Abraham Lincoln Memorial Hospital (B-212)  
 LITCHFIELD (Montgomery)  
     St. Francis Hospital (B-134)  
 MACKINAW (Tazewell)  
     Oak Knoll Sanatorium (E-40)  
 MACOMB (McDonough)  
     \*McDonough County District Hospital (F-163)  
 MANTENO (Kankakee)  
     Hillman Memorial Hospital (C-26)  
 MARION (Williamson)  
     \*Marion Memorial Hospital (D-75)  
 MATTOON (Coles)  
     \*\*Memorial District Hospital of Coles County (F-99)  
 MAYWOOD (Cook)  
     Loyola University Hospital (B-451)  
 McHENRY (McHenry)  
     \*\*McHenry Hospital (B-132)  
 McLEANSBORO (Hamilton)  
     \*Hamilton Memorial Hospital (F-32)  
 MELROSE PARK (Cook)  
     \*\*Gottlieb Memorial Hospital (B-212)  
     \*\*Westlake Community Hospital (B-139)

MENDOTA (LaSalle)  
   \*Mendota Community Hospital (B-58)  
 METROPOLIS (Massac)  
   \*Massac Memorial Hospital (F-57)  
 MOLINE (Rock Island)  
   \*\*Lutheran Hospital (B-270)  
   \*Moline Public Hospital (D-292)  
 MONMOUTH (Warren)  
   \*Community Memorial Hospital (D-80)  
 MONTICELLO (Piatt)  
   \*The John and Mary E. Kirby Hospital (B-35)  
 MOOSEHEART (Kane)  
   Mooseheart Hospital (B-43)  
 MORRIS (Grundy)  
   \*Morris Hospital (B-51)  
 MORRISON (Whiteside)  
   \*Morrison Community Hospital (F-32)  
 MOUNT CARMEL (Wabash)  
   \*Wabash General Hospital District (F-79)  
 MOUNT VERNON (Jefferson)  
   \*Good Samaritan Hospital (B-150)  
   Jefferson County Memorial Hospital (B-50)  
   Mt. Vernon State Tuberculosis Sanitarium (I-125)  
 MURPHYSBORO (Jackson)  
   \*St. Joseph Memorial Hospital (B-64)  
 NAPERVILLE (DuPage)  
   \*\*Edward Hospital (F-134)  
 NASHVILLE (Washington)  
   \*Washington County Hospital (F-36)  
 NORMAL (McLean)  
   \*Brokaw Hospital (B-142)  
 NORTHLAKE (Cook)  
   \*Northlake Community Hospital (B-111)  
 OAK FOREST (Cook)  
   Oak Forest Hospital (E-2,207)  
 OAK LAWN (Cook)  
   \*\*Christ Community Hospital (B-401)  
 OAK PARK (Cook)  
   \*\*Oak Park Hospital (B-241)  
   \*\*West Suburban Hospital (B-386)  
 OLNEY (Richland)  
   \*\*Richland Memorial Hospital (E-150)  
 OREGON (Ogle)  
   \*Warmolts Clinic (C-25)  
 OTTAWA (LaSalle)  
   Ottawa General Hospital (C-39)  
   \*\*Ryburn Memorial Hospital (D-117)  
 PANA (Christian)  
   \*Pana Community Hospital (B-69)  
 PARIS (Edgar)  
   \*Hospital & Medical Foundation of Paris, Inc. (B-70)  
 PARK RIDGE (Cook)  
   †\*\*Lutheran General Hospital (B-477)  
 PAXTON (Ford)  
   \*Paxton Community Hospital (B-39)  
 PEKIN (Tazewell)  
   \*Pekin Memorial Hospital (B-267)  
 PEORIA (Peoria)  
   †\*The Methodist Hospital of Central Illinois (B-481)  
   \*Peoria Munciple Tuberculosis Sanitarium (D-79)  
   \*Proctor Community Hospital (B-285)  
   †\*\*St. Francis Hospital (B-659)  
 PERU (LaSalle)  
   \*Peoples Hospital (B-105)  
 PINCKNEYVILLE (Perry)  
   \*Pinckneyville Community Hospital (F-55)  
 PITTSFIELD (Pike)  
   \*Illini Community Hospital (B-100)  
 PONTIAC (Livingston)  
   \*St. James Hospital (B-65)  
 PRINCETON (Bureau)  
   \*Perry Memorial Hospital (D-98)  
 QUINCY (Adams)  
   \*\*Blessing Hospital (B-236)  
   †\*\*St. Mary's Hospital (B-318)  
 RED BUD (Randolph)  
   \*St. Clement's Hospital (B-72)  
 ROBINSON (Crawford)  
   \*Crawford Memorial Hospital (F-64)  
 ROCHELLE (Ogle)  
   \*Rochelle Community Hospital (B-38)  
 ROCKFORD (Winnebago)  
   \*\*Rockford Memorial Hospital (B-333)  
   Rockford Munciple Tuberculosis Sanitarium (D-45)  
   \*\*St. Anthony Hospital (B-252)  
   †\*Swedish-American Hospital (B-307)  
 ROCK ISLAND (Rock Island)  
   \*Rock Island County Tuberculosis Sanitorium (E-71)  
   †\*\*St. Anthony's Hospital (B-240)  
 ROSICLARE (Hardin)  
   \*Hardin County General Hospital (B-27)  
 RUSHVILLE (Schuyler)  
   \*Sarah D. Culbertson Memorial Hospital (F-56)  
 ST. CHARLES (Kane)  
   \*\*Delnor Hospital (B-105)  
 SALEM (Marion)  
   \*Salem Memorial Hospital (B-36)  
 SANDWICH (DeKalb)  
   \*Sandwich Community Hospital (B-63)  
 SAVANNA (Carroll)  
   Savanna City Hospital (D-44)  
 SHELBYVILLE (Shelby)  
   \*Shelby County Memorial Hospital (B-79)  
 SILVIS (Rock Island)  
   Illini Hospital District (F-150)  
 SKOKIE (Cook)  
   \*\*Skokie Valley Community Hospital (B-153)  
 SPARTA (Randolph)  
   \*Sparta Community Hospital (F-30)  
 SPRINGFIELD (Sangamon)  
   †\*Memorial Hospital (B-469)  
   †\*\*St. John's Hospital (B-719)  
   St. John's Sanitorium (B-90)  
 SPRING VALLEY (Bureau)  
   \*St. Margaret's Hospital (B-147)  
 STAUNTON (Macoupin)  
   \*Community Memorial Hospital (B-71)



STERLING (Whiteside)	WATSEKA (Iroquois)
**Community General Hospital (D-143)	**Iroquois Hospital (B-76)
STREATOR (LaSalle)	WAUKEGAN (Lake)
**St. Mary's Hospital (B-244)	*Lake County General Hospital (E-53)
SYCAMORE (DeKalb)	*Lake County Tuberculosis Sanatorium (E-90)
*Sycamore Municipal Hospital (D-70)	*St. Therese Hospital (B-380)
TAYLORVILLE (Christian)	*Victory Memorial Hospital (B-346)
**St. Vincent Memorial Hospital (B-155)	WEDRON (LaSalle)
TUSCOLA (Douglas)	St. Joseph's Health Resort and Sanitarium (B-94)
*Douglas County Jarman Memorial Hospital (E-58)	WEST FRANKFORT (Franklin)
URBANA (Champaign)	*UMWA Union Hospital (B-84)
*Carle Foundation Hospital (B-156)	WHITE HALL (Greene)
*McKinley Memorial Hospital (I-62)	White Hall Hospital, Inc. (B-18)
†**Mercy Hospital (B-250)	WINFIELD (DuPage)
Outlook Champaign County Tuberculosis Sanatorium (E-25)	**Central DuPage Hospital (B-115)
University of Illinois Rehab. Center (I)	WOOD RIVER (Madison)
VANDALIA (Fayette)	*Wood River Township Hospital (H-73)
*Fayette County Hospital (F-95)	WOODSTOCK (McHenry)
	*Memorial Hospital for McHenry County (B-100)
	ZION (Lake)
	*Zion-Benton Hospital (B-104)

## HOSPITALS WITH SPECIAL TYPE OF SERVICE

		Type of Service
CASEYVILLE (St. Clair)	Pleasant View Sanitorium (E-70)	TB
CHICAGO (Cook)	*Booth Memorial Hospital (B-18)	Maternity
	*Schwab Rehabilitation Hospital (B-61)	Rehabilitation
	*Chicago Eye, Ear, Nose and Throat Hospital (C-37)	EENT
	*Chicago State Tuberculosis Sanitarium (I-336)	TB
	*The Children's Memorial Hospital (B-236)	Pediatric
	Halco Hospital, Inc. (C-10)	Alcoholic
	Illinois Children's Hospital-School (I-96)	Rehabilitation, Pediatric
	*Illinois Eye and Ear Infirmary (I-70)	EENT
	*LaRabida Jackson Park Sanitarium (B-104)	Pediatric
	*Martha Washington Hospital (B-50)	Chronic
	*Municipal Contagious Disease Hospital (D-100)	Alcoholic
	*Municipal Tuberculosis Sanitarium (D-1,000)	Contagious Disease
	*Rehabilitation Institute of Chicago (B-65)	TB
	St. Vincent's Infant Hospital (B-65)	Rehabilitation
	*Shriners Hospital for Crippled Children (B-68)	Pediatric
DECATUR (Macon)	Macon County Tuberculosis Sanitorium (E-41)	Orthopedic, Pediatric
HINSDALE (Cook)	*The Suburban Cook County Tuberculosis Sanitarium District (G-206)	TB
JOLIET (Will)	Sunny Hill Sanitorium (E-41)	TB
MACKINAW (Tazewell)	Oak Knoll Sanitorium (E-40)	TB
MOOSEHEART (Kane)	Moosehart Hospital (B-43)	Pediatric

## Hospitals with Special Type of Service (Continued)

MOUNT VERNON (Jefferson)	*Mount Vernon State Tuberculosis Sanitarium (I-125)	TB
OAK FOREST (Cook)	Oak Forest Hospital (E-2,463)	Chronic, Rehabilitation
OTTAWA (LaSalle)	*Ottawa General Hospital (C-39)	Chronic
PARK RIDGE (Cook)	*Lutheran General Hospital (B-477)	Alcoholic
PEORIA (Peoria)	*Peoria Municipal Tuberculosis Sanitarium (D-79)	TB
ROCKFORD (Winnebago)	Rockford Municipal Tuberculosis Sanitarium (D-45)	TB
ROCK ISLAND (Rock Island)	*Rock Island County Tuberculosis Sanitorium (E-71)	TB
SPRINGFIELD (Sangamon)	*St. John's Sanitorium (B-90)	TB
URBANA (Champaign)	Outlook Champaign County Tuberculosis Sanitorium (E-25)	TB
WAUKEGAN (Lake)	*Lake County Tuberculosis Sanatorium (E-90)	TB
WEDRON (LaSalle)	St. Joseph's Health Resort and Sanitarium (B-94)	Medical- Chronic

## STATE MENTAL HOSPITALS

ALTON (Madison)	GALESBURG (Knox)
Alton State Hospital (1,371)	*Galesburg State Research Hospital (1,843)
ANNA (Union)	JACKSONVILLE (Morgan)
Anna State Hospital (1,838)	*Jacksonville State Hospital (2,002)
CHICAGO (Cook)	KANKAKEE (Kankakee)
Chicago State Hospital (2,814)	*Kankakee State Hospital (2,493)
*Illinois State Psychiatric Institute (360)	MANTENO (Kankakee)
DANVILLE (Vermilion)	Manteno State Hospital (5,841)
*Veterans Administration Hospital (J-1,680)	MENARD (Randolph)
DOWNEY (Lake)	Illinois Security Hospital (400)
*Veterans Administration Hospital (J-2,487)	PEORIA (Peoria)
EAST MOLINE (Rock Island)	*Peoria State Hospital (1,660)
*East Moline State Hospital (1,343)	TINLEY PARK (Cook)
ELGIN (Kane)	Tinley Park Mental Health Center (480)
Elgin State Hospital (3,910)	

## PRIVATE MENTAL HOSPITALS

AURORA (Kane)	DES PLAINES (Cook)
*Mercyville Institute of Mental Health (B-130)	*Forest Hospital (C-105)
CHICAGO (Cook)	ELGIN (Kane)
*Fairview Hospital (C-100)	*Resthaven Hospital (C-100)
*Nicholas J. Pritzker Center (B-40)	FOREST PARK (Cook)
*Pinel Hospital Inc. (B-70)	*Riveredge (C-145)
*Ridgeway Hospital (B-99)	

## STATE SCHOOLS FOR MENTALLY DEFECTIVE

CENTRALIA (Marion)	DIXON (Lee)
Warren G. Murray Children's Center (558)	Dixon State School (3,336)
CHICAGO (Cook)	LINCOLN (Logan)
*Illinois State Pediatric Institute (264)	Lincoln State School (3,828)

## DIRECTORY OF LICENSED HOMES

The following list of homes licensed by the Illinois Department of Public Health (as of August, 1968) is divided into three sections: nursing homes, sheltered care homes, and homes for the aged. Ownership of these homes may be individual, partnership, corporation for profit, non-profit corporation, government, or trust-endowment.

A *Nursing Home* is equipped and staffed to provide personal and nursing care to all residents.

A *Sheltered Care Home* is equipped and staffed

to provide only personal services such as assistance with meals, dressing, bathing, etc., but not nursing care.

A *Home for the Aged* is operated not-for-profit under religious or fraternal auspices or under an endowment. It is operated primarily for persons over 60 years of age and may provide personal care only or nursing and personal care. Some of these homes for the aged provide special services over and above nursing care.

Figure in parentheses indicates number of beds.

### NURSING HOMES

**ABINGDON** (Knox County)  
Abingdon Nursing Home (74)  
W. Martin St.

**ALBION** (Edwards County)  
Rest Haven Manor, Inc. (49)  
120 W. Main St.

**ALEDO** (Mercer County)  
Mercer County Nursing Home (62)  
Rt. 4  
Oakview Nursing Home (49)  
3rd Ave. and 12th St.  
Twilight Haven (14)  
303 E. Seventh St.

**ALTON** (Madison County)  
College Avenue Nursing Home (19)  
920 College Ave.  
Eunice C. Smith Nursing Home (64)  
1251 College Ave.  
Main Street Nursing Home (40)  
1216 Main St.  
Riverview Nursing Home (23)  
440 Jefferson Avenue  
Villa Terrace Convalescent Home (28)  
510 Seminary Sq.  
Yinger Nursing and Convalescent Center (55)  
2349 Virden Dr.

**AMBOY** (Lee County)  
Forman Nursing Home (18)  
339 N. Mason Ave.

**ANNA** (Union County)  
Union County Skilled Nursing Home (60)  
517 N. Main St.

**ARCOLA** (Douglas County)  
Fishel Nursing Home (26)  
129 N. Pine St.

**ARLINGTON HEIGHTS** (Cook County)  
Americana Nursing Center of Arlington Heights  
715 W. Central Rd.  
Arlington Heights Rest Home (39)  
414 N. Vail St.  
Magnus Farm Nursing Home (99)  
801 E. Central Rd.

**AROMA PARK** (Kankakee County)  
Campbell Nursing Home (32)  
Fourth St., Box 271

**ARROWSMITH** (McLean County)  
DeArms Nursing Home (15)  
W. Crosson St.

**ARTHUR** (Moultrie County)  
The Arthur Home (41)  
423 Eberhardt Dr.

**ATLANTA** (Logan County)  
Bartmann Nursing Home (32)  
R. R. 1

**AUBURN** (Sangamon County)  
Parks Memorial Home (67)  
304 Maple St.

**AUGUSTA** (Hancock County)  
Augusta Nursing Home (18)  
E. Main St.

**AURORA** (Kane County)  
Aurora Manor, Inc. (112)  
1601 N. Farnsworth Ave.  
Colonial Nursing Home (19)  
422 N. Lake  
Elmwood Nursing Home (64)  
1017 W. Galena Blvd.

**AVON** (Warren County)  
Avon Nursing Home, Inc. (48)

**BARRINGTON** (Cook County)  
Barrington Rest Home, Inc. (50)  
145 W. Main St.

**BARRY** (Pike County)  
Barry Nursing Home (28)  
780 Grand St.  
Churchill Nursing Home (21)  
1038 Pratt St.

**BATAVIA** (Kane County)  
Kane County Home (85)  
Averill Rd., P.O. Box 267

**BEARDSTOWN** (Cass County)  
Boyd Nursing Home, Inc. (41)  
209-215 W. Third St.  
Brierly House Nursing Home, Inc. (34)  
604 State St.  
Elmwood Manor (49)  
13th & Grand Ave.  
Myers Nursing Home  
15th & Canal Sts.  
Parkview Nursing Home (29)  
903 E. Third St.



- BEAVERVILLE** (Iroquois County)  
Haven of Rest Nursing Home (44)  
Box 128
- BELLEVILLE** (St. Clair County)  
Atkinson Nursing Home (25)  
514 S. Jackson St.  
Calvin D. Johnson  
727 N. 17th St.  
Herald Nursing Home (24)  
506 Court St.  
Hillcrest Convalescent Home (24)  
420 Mascoutah Ave.  
Memorial Nursing Home (111)  
4315 Memorial Dr.
- BELVIDERE** (Boone County)  
Maple Crest Nursing Home (48)  
Boone County Home  
R.R. 1, Rt. 76  
Sutton's Nursing Home (34)  
226 N. State St.
- BEMENT** (Piatt County)  
Bement Rest Haven (27)  
101 S. Sangamon St.
- BENTON** (Franklin County)  
Franklin Hospital Skilled Nursing Care Unit  
(82)  
201 Bailey Ln.  
Linwood Nursing Home, Inc. (30)  
N. Main and Mitchell Sts.  
Rest Haven Nursing Home (28)  
418 W. Webster
- BERWYN** (Cook County)  
Fairfax Geriatric & Convalescent Center (106)  
3601 S. Harlem Ave.  
Pershing Convalescent Home, Inc. (63)  
3900 S. Oak Park Ave.  
R. N. Convalescent Home (51)  
6918 Windsor Ave.
- BLANDINSVILLE** (McDonough County)  
Newland Nursing Home (42)  
Van Buren and Breckenridge
- BLOOMINGDALE** (DuPage County)  
Elaine Boyd Creche (98)  
267 E. Lake St.  
Hilltop Foundation, Inc. (65)  
164 Prairie Ave.
- BLOOMINGTON** (McLean County)  
Heritage Manor (99)  
700 E. Walnut St.  
Maple Grove Nursing Home (86)  
S. Main Street Rd., RR #2  
Nel-Dor Arms Nursing Home (32)  
1116 E. Lafayette St.
- BLUE ISLAND** (Cook County)  
Bel-Air Nursing Home (28)  
2418 W. 127th St.  
Blue Island Nursing Home (35)  
2427 W. 127th St.  
Burr Oaks Nursing & Convalescent Center (38)  
2426 W. Burr Oaks Ave.
- BLUFORD** (Jefferson County)  
Schumm Nursing Home (38)
- BRADLEY** (Kankakee County)  
The Hallmark House (98)  
700 N. Kinzie, Rt. 54 North
- BROOKFIELD** (Cook County)  
Brookfield Nursing & Convalescent Home (21)  
9128 W. 31st St.  
Hill Haven Nursing Home (13)  
4548 Deyo
- BUNKER HILL** (Macoupin County)  
Tower View Nursing Home No. 1 (37)  
403 Morgan St.
- BURNHAM** (Cook County)  
The Homestead (96)  
14500 Manistee Ave.
- BUSHNELL** (McDonough County)  
The Elms (40)  
McDonough County Home  
1200 Washington Blvd.  
Heron Nursing Home (30)  
708 N. Dean St.
- CAMP POINT** (Adams County)  
Grandview Manor, Inc. (49)  
205 E. Spring St.
- CANTON** (Fulton County)  
Canton Nursing Home, Inc. (33)  
N. Main St.  
Sherwood Nursing Home (31)  
914 S. Main St.
- CARBONDALE** (Jackson County)  
Styrest Nursing Home (104)  
Rt. 4 on Tower Rd.
- CARLINVILLE** (Macoupin County)  
Joiner Nursing Home (35)  
706 N. Oak St.  
Lake View Nursing Home (74)  
R.R. 3  
Lee Nursing Home (10)  
334 Orient St.  
Macoupin County Nursing Home (98)  
R.R. 2  
Scherba's Nursing Home (16)  
817 N. High St.  
Weatherford Nursing Home (85)  
318 Buchanan St.  
Woodlawn Acres Convalescent and  
Nursing Home (30)  
W. Hard Rd., State Rt. 108
- CARMI** (White County)  
White County Nursing Home (90)  
R.R. 3  
Wilmar Restorium, Inc. (85)  
College Blvd.
- CARRIER MILLS** (Saline County)  
Carrier Mills Nursing Home, Inc.  
U.S. Route 45 East
- CARROLLTON** (Greene County)  
Tower View Nursing Home No. 2 (26)  
626 Maple Ave.

- CASEY (Clark County)  
Casey Nursing Home (92)  
N. 10th St.  
Rude's Goodwill Home (22)  
208 W. Main St.
- CASEYVILLE (St. Clair County)  
Caseyville Nursing Home (31)  
321 O'Fallon St.
- CENTRALIA (Marion County)  
Centralia Fireside House, Inc. (92)  
1030 E. McCord St.
- CHAMPAIGN (Champaign County)  
Americana Nursing Center of Champaign  
309 E. Springfield Ave.  
American Manor Convalescent Home (26)  
1002 W. Church St.  
Greenbrier Manor (126)  
1915 S. Mattis  
Leonard Nursing Home, Inc. (21)  
618 W. Church St.  
Oliver Nursing Home (22)  
1102 W. Church St.
- CHARLESTON (Coles County)  
Adkins Nursing Home (29)  
849 C St.  
Hillcrest Nursing Home, Inc. (56)  
635 Division St.  
Hilltop Nursing Home, Inc. (72)  
910 W. Polk St.  
Oakwood Convalescent Home (28)  
1041 Seventh St.  
Rennel's Nursing Home (15)  
214 Fifth St.
- CHESTER (Randolph County)  
Three Springs Lodge (63)  
R.R. 1
- CHICAGO (Cook County)  
A-1 Nursing Home, Inc. (43)  
4247 N. Hazel Ave.  
A-1 Nursing Home, Inc. (8)  
4249 N. Hazel  
Addison Manor, Inc. (40)  
3526 N. Reta Ave.  
Albany Park Kosher Nursing Home, Inc. (30)  
3418 W. Ainslie St.  
All American Nursing Home (144)  
5440-52 N. Broadway  
Alshore House (53)  
2840 Foster Ave.  
Anna Hadley Nursing Home (29)  
3209 W. Douglas Blvd.  
Austin Congress Nursing Home (136)  
901 S. Austin Blvd.  
Balmoral Home, Inc. (67)  
2055 W. Balmoral Ave.  
Beachview Convalescent Home, Inc. (47)  
6345 N. Sheridan Rd.  
Beacon Hill Nursing Home (33)  
4530 N. Beacon St.  
Beckwith Nursing Home (36)  
3240 W. Washington Blvd.
- Bell Nursing Home, Inc. (28)  
11079 S. Bell Ave.  
Belmont Rest Home, Inc. (55)  
1936 W. Belmont  
Beverly Hills Nursing Home (32)  
10347 S. Longwood Dr.  
Birchwood Beach Convalescent Home, Inc.  
No. 1 (39)  
7350 N. Sheridan Rd.  
Birchwood Beach Convalescent Home, Inc.  
No. 2 (32)  
7364 N. Sheridan Rd.  
Brightview Manor Convalescent Home  
4538 N. Beacon  
Brittany Terrace (49)  
930 N. LaSalle St.  
Byrn Mawr House, Inc. (183)  
6141 N. Pulaski Rd.  
Burke Nursing Home (10)  
11840 S. Western Ave.  
Burnside Rest Home (49)  
9435 South Langley Ave.  
Carmen Manor (114)  
1470 W. Carmen Ave.  
Davis Nursing Home, Inc. (85)  
725-29 Waveland Ave.  
Dearborn House, Inc. (128)  
2400 S. Dearborn St.  
Douglas Park Nursing Home (40)  
1518-22 S. Albany Ave.  
Edgewater Manor (42)  
5838 N. Sheridan Rd.  
Elizabeth Olivia Home (49)  
3952 S. Ellis Ave.  
Elston Home, Inc. (114)  
4340 N. Keystone Ave.  
Englewood Rest Haven, Inc. (26)  
7253 South Yale Ave.  
Fargo Beach Home, Inc. (149)  
7445 N. Sheridan Rd.  
Farwell Beach Convalescent Home (27)  
1145 W. Farwell Ave.  
Feinstein's Rest Home, Inc. (27)  
5960 N. Sheridan Rd.  
Fountainebleau Manor, Inc. (64)  
6318 N. Winthrop Ave.  
Fox River Rehabilitation Center (74)  
4700 N. Clarendon Ave.  
Fullerton Convalescent Home, Inc. (132)  
1400 W. Monroe St.  
Garden View Home, Inc. (130)  
6450 N. Ridge Ave.  
Garfield Nursing Home, Inc. (28)  
3834 W. Washington Blvd.  
Granville Manor (45)  
1021 Granville Ave.  
Harmon-Bragg Nursing Home, Inc.,  
No. 1 (25)  
6455 S. Kimbark Ave.  
Harmon-Bragg Nursing Home, Inc.,  
No. 2 (36)  
6463 S. Kimbark Ave.

- Hastings Nursing Home (14)  
7241 S. Princeton Ave.
- Hearthside Nursing Home, Inc. (73)  
1223 W. 87th St.
- Hollywood Convalescent Home, Inc. (45)  
1054 W. Hollywood Ave.
- Howard Convalescent Home, Inc. (32)  
6522 S. Harvard Ave.
- Ivory Nursing Home, Inc. (39)  
5837-5839 S. Calumet Ave.
- Johnson Nursing Home, Inc. (41)  
3319-3321 W. Fulton Blvd.
- Johnson Rehabilitation Nursing Home, Inc. (76)  
3456 W. Franklin Blvd.
- Kenmore House (109)  
5517 N. Kenmore Ave.
- Kostner Manor (117)  
1617 N. Kostner Ave.
- Lake Shore Nursing Home, Inc. (27)  
7230 N. Sheridan Rd.
- Lake View Manor Rest Home (42)  
2824 N. Sheridan Rd.
- Lehrer Nursing Home, Inc. (40)  
4636 N. Beacon St.
- Lincoln Park Home (33)  
2042 N. Orleans St.
- Linderman Nursing Home, Inc. (25)  
3311 W. Monroe St.
- Malden Nursing Home, Inc. (26)  
4616 N. Malden Ave.
- Mark Howard Home (93)  
4938 S. Drexel Blvd.
- Martha Washington Manor, Inc. (99)  
4515 S. Drexel Blvd.
- Melbourne Convalescent Home (188)  
4621-29 N. Racine Ave.
- Midwest Rest Haven, Inc. (90)  
310 S. Hamlin Ave.
- Miller Nursing Home (46)  
3256 W. Douglas Blvd.
- Misericordia Home (136)  
2916 W. 47th St.
- Monterey Convalescent Home (56)  
4616 S. Drexel Blvd.
- Monterey Convalescent Home (62)  
1919 S. Prairie Ave.
- Montgomery Convalescent Home (80)  
5956 S. Wabash Ave.
- Morkowicz Koshier Nursing Home (20)  
4851 N. Rockwell Ave.
- Mt. Pisgah Nursing Home (49)  
4220-28 S. Champlain Ave.
- Nesbitt Home (34)  
943 W. Foster Ave.
- North Shore Rest Haven, Inc. (49)  
7428 N. Rogers Ave.
- Ogden Park Convalescent Home (60)  
6617-25 S. Racine Ave.
- Panenka Nursing Home (25)  
1901 S. Lawndale Ave.
- Park House (86)  
2320 S. Lawndale Ave.
- Patterson Convalescent Home (32)  
3242 W. Maypole Ave.
- Pedraza Nursing Home, Inc., No. 1 (31)  
3230 W. Washington Blvd.
- Pedraza Nursing Home, Inc., No. 2 (19)  
3234 W. Washington Blvd.
- Peyton Convelascent Home (44)  
4541 S. Michigan Ave.
- Rabbi Meisels Convalescent Home, Inc. (49)  
4900 N. Bernard St.
- Ridge Manor Convalescent Home (35)  
5888 N. Ridge Ave.
- Rogers Park Manor Nursing Home  
& Convalescent Center (91)  
1512 W. Fargo Ave.
- Rosewood Manor, Inc. (127)  
6700 N. Damen Ave.
- Royal Manor (28)  
5640 N. Sheridan Rd.
- St. Michael's Rest Haven, Inc. (43)  
4815 S. Drexel Blvd.
- Schiller Rest Home, Inc. (30)  
1428 W. Jarvis
- Sheridan Gardens Convalescent Home, Inc. (99)  
1426 W. Birchwood Ave.
- Shorecrest Convalescent Home, Inc. (35)  
7331 N. Sheridan Rd.
- Shore View Manor Convalescent Home, Inc. (31)  
2719 E. 75th St.
- South Shore Koshier Rest Home, Inc. (111)  
7325 S. Exchange Ave.
- South Shore Pavilion (113)  
7750 South Shore Dr.
- The Sovereign Home (55)  
6159 N. Kenmore Ave.
- Stern's Convalescent Home, Inc. (37)  
730 Waveland St.
- Stewart Nursing Home, Inc. (23)  
6710 Stewart Ave.
- Sunnyside Nursing Home (47)  
4537 N. Greenview Ave.
- Sunset Nursing Home, Inc. (192)  
7270 South Shore Dr.
- Thorndale Manor (41)  
1020 W. Thorndale Ave.
- Uptown Convalescent Home (55)  
4646 N. Beacon St.
- Vincinnes Manor, Inc. (305)  
4724 Vincinnes Ave.
- Wellington Plaza (91)  
504 W. Wellington Ave.
- Wendt Nursing Home (33)  
5914 N. Sheridan Rd.
- West Side Nursing Home, Inc. (36)  
1900 S. Kedzie Ave.
- Whitehall Convalescent and Nursing  
Home, The (91)  
1901 N. Lincoln Park West



- Wincrest Nursing Home, Inc. (85)  
6326 N. Winthrop Ave.
- Winston Manor Convalescent and Nursing Home, Inc. (178)  
2155 W. Pierce Ave.
- Wrightwood Nursing Home, Inc. (90)  
2732 North Hampden Ct.
- CHICAGO HEIGHTS (Cook County)  
Chicago Heights Nursing Home (21)  
309 W. 16th St.
- Riviera Manor Nursing Home, Inc. (110)  
490 W. 16th Pl.
- CHILLICOTHE (Peoria County)  
Parkhill Extended Care Facility (66)  
Hillcrest Drive
- CLINTON (DeWitt County)  
Crest View Nursing Home (48)  
U. S. Hwy. 51 N.
- DeWitt County Nursing Home (42)  
R.R. 1
- Pine Crest Nursing Home (41)  
North Center Limits
- COAL VALLEY (Rock Island County)  
Oak Glen Nursing Home (286)
- COLCHESTER (McDonough County)  
Colchester Nursing Home (49)  
Hunt Street
- Helton Nursing Home (15)  
East St., Box 334
- COLLINSVILLE (Madison County)  
Pleasant Rest Nursing Home (89)  
614 N. Summit Ave.
- CREAL SPRINGS (Williamson County)  
Creal Springs Nursing Home (45)  
S. Line St.
- CRESTWOOD (Cook County)  
Rest Haven Illiana Christian  
Convalescent Home, Inc. (99)  
13259 S. Central Ave., (P.O. Palos Heights)
- DANVILLE (Vermilion County)  
Colonial Manor, Inc. (55)  
629 Warrington Ave.
- Danville Care, Inc. (98)  
1701 N. Bowman Ave.
- Danville Care, Inc. North (72)  
1715 N. Bowman Ave.
- Nance Nursing Home (14)  
622 Bryan Ave.
- Vermilion County Nursing Home (191)  
R.R. 1, Box 13
- DECATUR (Macon County)  
Americana Nursing Center of Decatur (95)  
444 W. Harrison St.
- Lakeshore Manor (99)  
1293 S. 34th St.
- Mabel's Nursing Home (29)  
820 W. North St.
- Macon County Tuberculosis Sanatorium  
& Nursing Home (34)  
400 W. Hay
- Mary Ann's (28)  
640 W. Main St.
- Muirheid Nursing Home (20)  
231 E. Condit St.
- Muirheid's Nightingale Manor (42)  
805 E. Johns Ave.
- Strong's Nursing Home (18)  
936 N. Church St.
- Wakefield McKinley Avenue Nursing Center,  
Inc. (26)  
800 W. McKinley Ave.
- Wakefield Water Street Nursing Center, Inc. (22)  
1504 N. Water St.
- West View Nursing Home (19)  
628 W. Main St.
- DeKALB (DeKalb County)  
DeKalb County Nursing Home (136)  
Sycamore Rd., R.R. 23
- Pine Acres Retirement Center (60)  
1212 S. Second St.
- DES PLAINES (Cook County)  
Brookwood Convalescent Center, Inc. (119)  
Lyman and Dempster Sts.
- DesPlaines Convalescent Home (28)  
866 Lee St.
- Golf Road Pavilion (142)  
9555 W. Golf Rd.
- Graceland Home of DesPlaines, Inc. (41)  
545 Graceland Ave.
- DIXMOOR (Cook County)  
Starnes Nursing Home, Inc. (39)  
14434 S. Hoyne Ave.
- DIXON (Lee County)  
Lee County Nursing Home (84)  
R.R. 4
- Orchard Glen, Inc. (58)  
141 N. Court St.
- DOLTON (Cook County)  
Sandra Memorial Nursing and Convalescent  
Home, Inc. (61)  
14325 S. Blackstone Ave.
- DOWNER'S GROVE (DuPage County)  
Highland House Nursing Home, Inc. (62)  
35th St. and Highland Ave.
- DUNDEE (Kane County)  
Bowes Nursing Home (49)  
305 Oregon St.
- DUQUOIN (Perry County)  
Fair Acres Nursing Home (76)  
514 E. Jackson St.
- DURAND (Winnebago County)  
Medina Nursing Center (66)  
P.O. Box 538
- EAST DUNDEE (Kane County)  
Gregg Nursing Home (31)  
417 E. Hill St.
- EAST ST. LOUIS (St. Clair County)  
Carr Nursing Home (47)  
3110 Bond Ave.
- Fletcher Ann Convalescent Home (38)  
2640 St. Louis Ave.
- Lively Nursing Home (32)  
1303 Baugh Ave.

EDWARDSVILLE (Madison County)  
 Anna-Henry Nursing Home (84)  
 637 Hillsboro  
 Madison County Nursing Home (59)  
 Main St.

EFFINGHAM (Effingham County)  
 Marks Nursing Home (20)  
 406 E. Jefferson  
 Rollin Hills Rest Home (96)  
 Rollin Hills Subdivision

ELDORADO (Saline County)  
 Eldorado Nursing Home, Inc. (49)  
 Third and Locust Sts.  
 Good Shepherd Nursing Home No. 1 (61)  
 First and Jasper Sts.

ELGIN (Cook County)  
 Little Angels (45)  
 Rt. 3, Box 201A, Rt. 58

ELGIN (Kane County)  
 Daybreak Nursing Home (27)  
 420 Douglas Ave.  
 Elgin-Bowes Nursing Home (49)  
 105 N. Gifford St.  
 Hillcrest Convalescent Home, Inc. (26)  
 4 N. Jackson St.  
 Isabelle Home (18)  
 104 S. State St.  
 Mary Margaret Manor (94)  
 134 N. McLean Blvd.  
 Oliver Nursing Home, Inc. (25)  
 325 Watch St.  
 Raloff Nursing Home (10)  
 316 Division St.  
 Simpson House, Ltd. (67)  
 170 S. State St.

ELIZABETH (Jo Daviess County)  
 Elizabeth Nursing Home, Inc.  
 540 Pleasant St.

ELMHURST (DuPage County)  
 Elmhurst Extended Care Center, Inc. (42)  
 200 E. Lake St.

ELMWOOD (Peoria County)  
 Elm Haven, Inc. (75)

EL PASO (Woodford County)  
 Lewis Nursing Home, Inc. (17)  
 487 Elmwood Ct.  
 McDaniel Nursing Home (33)  
 404 E. First St.

EVANSTON (Cook County)  
 Broad Nursing Home (25)  
 2001 Orrington Ave.  
 Dobson Plaza, Inc. (52)  
 120 Dodge Ave.  
 Evanston Convalescent Center (65)  
 1300 Oak Ave.  
 Klingler Nursing Home (5)  
 2306 Ridge Ave.  
 Pembridge House, Inc. (96)  
 1406 Chicago Ave.  
 Three Oaks Nursing Center (124)  
 500 Asbury Ave.

EVERGREEN PARK (Cook County)  
 AAA Park Lawn Nursing Home (20)  
 9307 S. Crawford Ave.  
 Evergreen Gardens, Inc. (162)  
 9125 S. Crawford Ave.  
 Evergreen Manor Nursing Home (22)  
 3327 W. 95th St.  
 Gunderson Convalescent & Nursing  
 Home (17)  
 2701 W. 95th St.  
 Peace Memorial Home (220)  
 10124 S. Kedzie Ave.

FAIRBURY (Livingston County)  
 Helen Lewis Smith Pavilion (23)  
 519 S. Sixth St.

FAIRFIELD (Wayne County)  
 Way-Fair Restorium (23)  
 11th & Harding Sts.

FARMER CITY (DeWitt County)  
 Farmer City Nursing Home, Inc. (22)  
 326 Clinton Ave.  
 Jackson Heights Nursing Home (49)  
 Brookview Dr. and Crabtree Ct.

FLORA (Clay County)  
 Flora Nursing Center (50)  
 701 Shadewell  
 Raber Nursing Home (28)  
 402 E. Fourth St.

FRANKLIN GROVE (Lee)  
 Franklin Grove Nursing Center  
 North State Street

FREEPORT (Stephenson County)  
 Benjamin Stephenson Nursing Home (56)  
 Walnut Rd.  
 Crestview Manor, Inc. (42)  
 565 N. Turner Ave.  
 Van Buren Nursing Home (20)  
 503 N. Van Buren

FULTON (Whiteside County)  
 Harbor Crest Home, Inc. (49)  
 810 E. 17th St.

GALATIA (Saline County)  
 Good Shepherd Nursing Home No. 2 (45)  
 Main and Cross Sts.

GALESBURG (Knox County)  
 Americana Nursing Center of Galesburg (67)  
 270 E. Losey at Kellogg  
 Campbell Nursing Home (16)  
 731 N. Seminary  
 Schrader Nursing Home (20)  
 490 N. Cherry

GENESEO (Henry County)  
 Hillcrest Home (126)  
 426 W. First St.  
 Wright Nursing Home (28)  
 R.R. 4

GENEVA (Kane County)  
 Anna Baum Home (36)  
 115 Campbell St.

GENOA (DeKalb County)  
 Villa Nursing Home (30)  
 119 Main St.

GIBSON CITY (Ford County)  
 Gibson Community Hospital Annex (40)  
 430 E. 19th St.  
 Gibson Manor, Inc. (47)  
 525 Hazel Dr.

GILLESPIE (Macoupin County)  
 County View Nursing Home  
 R.R. #3  
 Tower View Nursing Home No. 3 (8)  
 703 S. Second St.

GLEN ELLYN (DuPage County)  
 Manor Convalescent Home, Inc. (49)  
 818 DuPage Rd.

GLENVIEW (Cook County)  
 Golf Mill Nursing Home, Inc. (166)  
 77 Greenwood Ave.  
 Whitehaven Acres, Inc. (32)  
 Greenwood Ave. and Melody Ln.

GODFREY (Madison County)  
 Beverly Farm Foundation  
 Humbert Road  
 Blu-Fountain Manor, Inc. (75)  
 Rt. 100

GRANITE CITY (Madison County)  
 The Colonnades (82)  
 1 Colonial Dr.

GRAYVILLE (White County)  
 Baldwin Nursing Home, Inc. (54)  
 305 W. North St.

GREENFIELD (Greene County)  
 Cedar Knoll Nursing and Convalescent  
 Home(29)  
 711 Bluff St.

GREENVILLE (Bond County)  
 Bourgeois Nursing Home, Inc. (32)  
 100 W. College St.

GREENUP (Cumberland)  
 Cumberland Nursing Center  
 P.O. Box 755

HAMPSHIRE (Kane County)  
 Hampshire Nursing Home (62)  
 Jackson and Warner Sts.  
 Lydia Nursing Home (20)  
 25 W. Jackson St.

HARDIN (Calhoun County)  
 Sunrise Nursing Home (20)  
 R.R. 2

HARRISBURG (Saline County)  
 Bacon's Nursing Home, Inc. (21)  
 Box 269, N. Granger St.  
 Country Club Manor (68)  
 1000 W. Sloan Street

HARVARD (McHenry County)  
 Harvard Rest Home (44)  
 210 E. Front St.

HARVEY (Cook County)  
 Heather Manor Convalescent Center (49)  
 15600 S. Honore Ave.

HAVANA (Mason County)  
 Havana Nursing Home (43)  
 224 W. Mound St.

HERRIN (Williamson County)  
 Hampton Nursing Home (30)  
 321 S. 14th St.  
 Mattingly Nursing Home, Inc. (34)  
 920 S. 14th St.

HICKORY HILLS (Cook County)  
 Villa Marie Incorporated (78)  
 9246 S. Roberts Rd., (P.O. Oak Lawn)

HIGHLAND (Madison County)  
 Helvetia Nursing Home (49)  
 2510 Lemon Street Rd.  
 Miles Nursing Home (26)  
 817 Ninth St.

HIGHLAND PARK (Lake County)  
 Abbott House (65)  
 405 Central Ave.

HIGHWOOD (Lake County)  
 Pavilion of Highland Park (59)  
 50 Pleasant Ave.

HILLSIDE (Cook County)  
 Oakridge Convalescent Home (42)  
 323 Oakridge Ave.

HINSDALE (DuPage County)  
 Oaks Nursing Home (49)  
 Rt. 83 and 91st St.  
 Shank Rest Home (31)  
 525 W. Ogden Ave.

HOPEDALE (Tazewell County)  
 Hopedale Nursing Home (86)  
 Second St.

IRVING (Montgomery County)  
 Rest Haven, Inc. (30)

JACKSONVILLE (Morgan County)  
 Lasley Nursing Home (20)  
 844 W. College Ave.  
 Meline Nursing Center (90)  
 1024 W. Walnut St.  
 Modern Care Convalescent and Nursing  
 Home (40)  
 1500 W. Walnut St.

JERSEYVILLE (Jersey County)  
 Garnet Nursing Home (37)  
 602 W. Pearl St.  
 Garnet's Chateau (48)  
 608 W. Pearl St.  
 Green Lawn Nursing Home (35)  
 518 S. State St.  
 Waters Nursing Home (21)  
 408 N. Giddings St.

JOLIET (Will County)  
 Americana Nursing Center of Joliet (92)  
 300 N. Madison  
 Broadway Nursing Home (70)  
 216 N. Broadway  
 LeSan Nursing Home (25)  
 601 Campbell St.  
 Lincoln Nursing Home (142)  
 611 E. Cass St.  
 Pleasant Center Nursing Home (38)  
 5 S. Center St.  
 Sunny Hill Nursing Home (59)  
 501 Ella Ave.



- KANKAKEE (Kankakee County)  
 Americana Nursing Center of Kankakee (91)  
 900 W. River Pl.  
 Casper Nursing Home (30)  
 480 E. Oak St.  
 Deerwood Convalescent Home (57)  
 R.R. 5, Walden Road
- KEWANEE (Henry County)  
 St. Francis Continuing Care Home  
 573 Elliot St.
- KNOXVILLE (Knox County)  
 Good Samaritan Nursing Home (49)  
 407 N. Hebart St.  
 Knox County Nursing Home (200)  
 219 N. Market St.  
 St. Martha's Nursing Home, Inc. (47)  
 N. Market St.
- LACON (Marshall County)  
 St. Joseph's Nursing Home (54)  
 401 Ninth St.
- LaGRANGE (Cook County)  
 LaGrange Colonial Manor Convalescent and  
 Nursing Center (179)  
 339 N. Ninth Ave.  
 LaGrange Convalescent and Nursing  
 Center (58)  
 42 S. Ashland Ave.
- LAKE BLUFF (Lake County)  
 Hill Top Farm (14)  
 502 N. Waukegan Rd.
- LAKE VILLA (Lake County)  
 Hampstead House (28)  
 601 S. Rt. 59  
 Lake Villa Nursing Home (30)  
 201 Cedar Ave.  
 Venetian Manor Convalescent Home (30)  
 1913 E. Grand Ave., Lindenhurst Addition
- LAKE ZURICH (Lake County)  
 Bee Dozier's Maple Hill Nursing Home,  
 Inc. (86)  
 P.O. Box 288
- LANSING (Cook County)  
 Tri-State Manor Nursing Home (56)  
 2500—175th St.
- LAWRENCEVILLE (Lawrence County)  
 Shidler Nursing Home (22)  
 1022 Twelfth St.
- LEBANON (St. Clair County)  
 Bohannon Nursing Home, Inc. (24)  
 404 S. Fritz St.
- LENA (Stephenson County)  
 Ortiz Convalescent Home (33)  
 516 Schuyler St.
- LEWISTOWN (Fulton County)  
 Clarytona Manor, Inc. (96)  
 Sycamore Dr.
- LEXINGTON (McLean County)  
 Three Oaks Nursing Home (48)  
 301 S. Vine St.
- LIBERTYVILLE (Lake County)  
 Lake County Nursing Home (153)  
 1125 N. Milwaukee Ave.
- Magnus Rest Home (25)  
 1206 S. Milwaukee Ave.
- LINCOLN (Logan County)  
 Abraham Lincoln Memorial Extended  
 Care (58)  
 315 Eighth St.  
 Christian Nursing Home (48)  
 1507 Seventh St.  
 Mary Henry Nursing Home (55)  
 1800 Fifth St.  
 Myrick's Lincoln Nursing Home (27)  
 1011 Third St.
- LITCHFIELD (Montgomery County)  
 Friendly Haven Nursing Home (28)  
 823 Chapin St.  
 Litchfield Nursing Home (62)  
 628 S. Illinois St.
- LOVES PARK (Winnebago County)  
 Fountain Terrace (49)  
 6131 N. 2nd St.
- MACOMB (McDonough County)  
 Americana Nursing Center of Macomb (58)  
 120 Doctors Ln.
- MARENGO (McHenry County)  
 Florence Nursing Home (41)  
 546 E. Grant Hwy.
- MARION (Williamson County)  
 Fountains Nursing Home (68)  
 1301 E. DeYoung St.
- MAROA (Macon County)  
 Villa Maria Nursing Home (14)  
 125 S. Main St.
- MARSEILLES (La Salle)  
 Rivershores Nursing Home  
 West Commercial St.
- MARSHALL (Clark County)  
 Burnsides Nursing Home, Inc. (90)  
 410-412 N. Second St.
- MARYVILLE (Madison)  
 Collinsville/Colonial Nursing Home  
 Interstate 70 & 159
- MASCOUTAH (St. Clair County)  
 Grange Nursing Home (29)  
 901 N. Tenth St. (RR. 1, Box 145)  
 Mascoutah Nursing Home (22)  
 213 E. Church St.  
 West Main Nursing Home (16)  
 1244 W. Main St.
- MASON CITY (Mason County)  
 Christian Care Nursing Home (21)  
 705 E. Chestnut St.
- MATTOON (Coles County)  
 Cunningham Nursing Home (31)  
 1312 Wabash Ave.  
 Douglas Nursing Center (49)  
 State Hwy. #121 West
- MAYWOOD (Cook County)  
 Lendino Nursing Home, Inc. (14)  
 1110 S. Ninth Ave.
- McHENRY (McHenry County)  
 Villa Nursing Home (68)  
 1201 W. Rocky Beach

- MENDOTA (LaSalle County)  
Sunrise Nursing Home (49)  
1201 First Ave.
- METROPOLIS (Massac County)  
Metropolis Good Samaritan Home (48)  
Box 885
- MIDLOTHIAN (Cook County)  
Bowman Nursing Home, Inc., No. 1 (49)  
3249 W. 147th St.  
Bowman Nursing Home, Inc., No. 2 (44)  
14731 S. Turner Ave.  
Clover Acres (49)  
5252 W. 147th St.  
Largent's Convalescent Home (68)  
4323 W. 147th St.  
Maple Farms Convalescent Home (44)  
147th & Long Ave.
- MILAN (Rock Island County)  
Comfort Harbor Nursing Home (39)  
114 W. Second Ave.
- MINONK (Woodford County)  
Minonk Manor, Inc. (48)  
201 Locust St.
- MOLINE (Rock Island County)  
Americana Nursing Center of Moline (67)  
833 Sixteenth St.  
Fairhaven Nursing Home (28)  
2525 Ninth Ave.
- MONMOUTH (Warren County)  
Colonial Nursing Home, Inc. (23)  
303 E. Broadway  
Monmouth Nursing Home (28)  
116 South H Street  
Warren County Nursing Home (39)  
R.R. 4
- MONTICELLO (Piatt County)  
Cozy Haven Nursing Home (10)  
713 W. Bond St.  
Piatt County Nursing Home (32)  
R.R. 2
- MORRIS (Grundy County)  
Grundy County Home (49)  
Clay & Quarry Sts.  
Morris Lincoln Nursing Home (84)  
916 Fremont Ave.
- MORRISON (Whiteside County)  
Eveningside Nursing Home (23)  
509 N. Genesee St.
- MORRISONVILLE (Christian County)  
Memorial Nursing Home (47)  
200 W. Fifth St.
- MORTON (Tazewell County)  
Restmor, Inc. (78)  
935 E. Jefferson
- MT. CARMEL (Wabash County)  
Monticello Nursing Home, Inc. (97)  
Box 229  
Wabash Nursing Home (30)  
R.R. 3
- MT. STERLING (Brown County)  
Barker's Nursing Home (15)  
204-206 Railroad Ave.
- Haley's Nursing Home (10)  
401 W. Main St.  
Modern Manor, Inc.  
Camden Rd.  
Whited Nursing Home (20)  
308 N. Capital St.
- MT. VERNON (Jefferson County)  
Hickory Grove Manor (111)  
8 Doctors Park Rd.  
Setzekorn Nursing Home (31)  
1300 Broadway
- MT. ZION (Macon County)  
Woodland, Inc., Nursing Home (70)
- MUNDELEIN (Lake County)  
North Riverwood Manor, Inc. (65)  
Rt. 1, Box 106
- MURPHYSBORO (Jackson County)  
Jackson County Nursing Home (158)  
1441 N. 14th St.  
Tyler Nursing Home, Inc. (68)  
1711 Spruce St.
- NAPERVILLE (DuPage County)  
American Nursing Center of Naperville (97)  
200 Martin Dr.  
Brentwood Nursing Home (29)  
1136 Mill St.
- NASHVILLE (Washington County)  
Friendship Manor, Inc. (125)  
Friendship Dr.
- NEWTON (Jasper County)  
Newton Rest Haven (92)  
300 S. Scott St.
- NILES (Cook County)  
Gross Point Manor (99)  
6601 Touhy Ave.  
Pleasantview Convalescent and Nursing  
Center, Inc. (91)  
6840 W. Touhy Ave.  
Svithiod Nursing Home (23)  
8800 Grace St.
- NORMAL (McLean County)  
Americana Nursing Center of  
Bloomington-Normal (88)  
510 Broadway
- NORTHBROOK (Cook County)  
Eden View Convalescent and Geriatric  
Center, Inc. (142)  
222 Frontage Rd.  
Northbrook Nursing Home & Rehabilitation  
Center, Inc. (149)  
270 Skokie Rd.
- OAK LAWN (Cook County)  
Brentwood Nursing and Convalescent Home,  
Inc. (92)  
5432 W. 87th St.  
Concord Nursing Home (91)  
9401 Ridgeland Ave.  
Monticello Convalescent Center (99)  
6300 W. 95th St.  
Oak Lawn Convalescent and Geriatric  
Home (95)  
9525 S. Mayfield

Parkside Gardens Nursing Home (77)  
5701 W. 79th St.

OAK PARK (Cook County)  
Oak Park Nursing Home, Inc. (41)  
637 S. Maple Ave.  
Royal Oak Convalescent and Geriatric  
Center (204)  
625 N. Harlem Ave.  
The Woodbine (59)  
6909 W. North Ave.

ODIN (Marion County)  
Wutzler Nursing Home (29)  
Kirkwood St.  
Yaw Nursing Home (61)  
Laury St.

O'FALLON (St. Clair County)  
Parkview Colonial Manor (107)  
300 Weber Road

OKAWVILLE (Washington County)  
Washington Springs Nursing Home (130)  
Front & Belleville St.

OLNEY (Richland County)  
Burgin Nursing Home No. 1 (31)  
305 S. Washington St.  
Burgin Nursing Home No. 2 (29)  
607 S. Elliott St.  
Burgin Nursing Manor (75)  
928 E. Scott St.  
Marks Nursing Home (28)  
217 N. Fair St.

ORANGEVILLE (Stephenson County)  
Krug Convalescent Home (13)  
High St.

OTTAWA (LaSalle County)  
Hassley's Health Haven (16)  
Gentleman Rd., R.R. 4  
Highland Sanatorium and Convalescent  
Home of LaSalle County (61)  
800 East Center St.  
LaSalle County Home (68)  
R.F.D. 1

PALATINE (Cook County)  
Bee Dozier's Palatine Nursing Home (40)  
W. Dundee Rd.  
Plum Grove Nursing Home, Inc. (48)  
24 S. Plum Grove Ave.

PALOS HILLS (Cook County)  
Palos Hills Convalescent Center (130)  
10426 S. Roberts Rd.

PANA (Christian County)  
DePaape-Ashcraft Nursing Home (83)  
10 Oak St.

PARK RIDGE (Cook County)  
Park Ridge Terrace (56)  
665 Busse Avenue

PAXTON (Ford County)  
Ford County Nursing Home (74)  
R.R. 2  
Lyons Nursing Home (21)  
440 E. Pells St.

PEKIN (Tazewell County)  
Americana Nursing Center (49)  
Allentown Rd.  
Floy's Nursing Home (24)  
803 Park Ave.

PEORIA (Peoria County)  
Americana Nursing Center of Peoria (65)  
5600 Glen Elm Dr.  
Baker Nursing Home (28)  
500-502 W. Second St.  
Bel-Wood Nursing Home (237)  
6701 W. Planck Rd.  
High View Nursing Home (98)  
2308 W. Nebraska St.  
Mahoney Nursing Home No. 1 (28)  
444 W. Second St.  
Mahoney Nursing Home No. 2 (19)  
2149 N. Knoxville St.  
Walker Nursing Home (16)  
1504 W. Garden St.

PEORIA HEIGHTS (Peoria County)  
Fireside House, Inc. (108)  
1629 Gardner Ln.  
Galena Park Home (24)  
5533 N. Galena Rd.

PERU (LaSalle County)  
Heritage Manor (96)  
22nd and Rock Sts.  
Tri City Nursing Home (21)  
2804 Sixth St.

PETERSBURG (Menard County)  
Menard Convalescent Center, Inc. (54)  
120 West Antle St.  
Sunny Acres Nursing Home (58)  
Rt. 3

PITTSFIELD (Pike County)  
Couch Nursing Home (35)  
521 E. Washington St.  
Pittsfield Nursing Home (74)  
R.R. 3

PONTIAC (Livingston County)  
Livingston County Nursing Home (120)  
R.R. 1  
The Convalescent Center (25)  
East Torrence Avenue

PRAIRIE CITY (McDonough County)  
Westfall K & C. Nursing Home (9)  
Reed and Union Sts.  
Westfall Nursing Home (22)  
Madison and Union Sts.

PRINCETON (Bureau County)  
Prairie View Nursing Home (149)  
R.R. 5

PROPHETSTOWN (Whiteside)  
Prophets Riverview Good Samaritan Center  
(68)  
310 Mosher Drive

QUINCY (Adams County)  
Eloise Nursing Home (13)  
1614 N. Fourth St.  
Hall Nursing Home (23)  
1870 Vermont St.



- Lincoln-Terrace Nursing Home, Inc. (99)  
1315 N. Eighth St.  
St. Joseph Hall (72)  
1415 Vermont St.  
Theda Boll Nursing Home (14)  
438 N. Twelfth St.
- RAYMOND (Montgomery County)  
Cottage Nursing Home (33)  
400 W. Sparks St.
- ROANOKE (Woodford County)  
Roanoke Manor, Inc. (79)  
1102 W. Randolph St.
- ROBBINS (Cook County)  
Esma A. Wright Convalescent Center (206)  
139th St. at Lydia
- ROBINSON (Crawford County)  
Gowen Nursing Home (49)  
902 Mefford St.  
Robinson Nursing Home (44)  
503 E. Main St.
- ROCHELLE (Ogle County)  
Americana Nursing Center of Rochelle (49)  
900 N. Third St.
- ROCK FALLS (Whiteside County)  
Colonial Acres Rest Home (55)  
Rt. 2, Dixon Rd.
- ROCKFORD (Winnebago County)  
Alma Nelson Manor (174)  
550 S. Mulford Rd.  
Americana Nursing Center of Rockford (113)  
2313 N. Rockton  
Deacon Home (17)  
611 N. Court St.  
Johnson's Hill Top Nursing Home (16)  
728 N. Court St.  
Lund Nursing Home (17)  
1503 Fourth Ave.  
North Rockford Convalescent Home (49)  
1925 Fremont St.  
The Restorium (41)  
2800 S. Main St.  
River Bluff Nursing Home (204)  
4401 N. Main Rd.  
Riverside Manor, Inc. (108)  
707 W. Riverside Blvd.  
Rockford Municipal Sanitarium Nursing Home (59)  
1601 Parkview Ave.
- ROCK ISLAND (Rock Island County)  
Mrs. Carroll's Nursing Home (26)  
4434 Seventh Ave.  
Parkway Rest Home (22)  
557—30th St.  
Shady Lawn Nursing Home, Inc. (29)  
1018 Twelfth St.
- ROSSVILLE (Vermilion County)  
Hedrecka Nursing Home (32)  
R.R. 2
- ROUND GROVE (Whiteside County)  
Whiteside County Nursing Home (75)
- RUSHVILLE (Schuyler County)  
Hills Convalescent Home (20)  
717 E. Adams  
Snyder's Home (49)  
135 Morgan St.
- RUTLAND (LaSalle County)  
Rutland Nursing Home, Inc. (27)  
E. Front St. and Chestnut St.
- ST. ELMO (Fayette County)  
Elm Haven Nursing Home (24)  
317 Cumberland Rd.  
Heritage Home of America  
Route 40 East
- SALEM (Marion County)  
Twin Willows Nursing Center (72)  
Rt. 37 North
- SANDWICH (DeKalb County)  
Sandhaven, Inc. (37)  
517 N. Main St.
- SAYBROOK (McLean County)  
Kinsell's Nursing Home, Inc. (16)  
205 N. Main St.
- SHANNON (Carroll County)  
Johnson's Nursing Home (59)  
418 Ridge St.
- SHAWNEETOWN (Gallatin County)  
Loretta Nursing Home (61)  
Logan and Lincoln Sts.
- SHELBYVILLE (Shelby County)  
Young's Shelbyville Restorium, Inc. (110)  
Rt. 128 North
- SHELDON (Iroquois County)  
Happy Siesta (40)  
220 E. Center St.
- SIDELL (Vermilion County)  
Fairview Alliance Home, Inc. (39)  
R.R. 1
- SILVIS (Rock Island County)  
Happy Haven Rest Home (49)  
118 Tenth St.
- SKOKIE (Cook County)  
Old Orchard Manor (61)  
4660 Old Orchard Rd.  
Skokie Valley Manor, Inc. (115)  
4600 Golf Road  
Village Nursing Home in Skokie, Inc. (128)  
9000 Laverne Ave.
- SMITHBORO (Bond County)  
American Nursing Home (30)
- SOUTH CHICAGO HEIGHTS (Cook County)  
Suburban Convalescent Center (99)  
120 W. 26th St.
- SOUTH HOLLAND (Cook County)  
Colonial Convalescent Home (65)  
549 E. 162nd St.
- SPARTA (Randolph County)  
Randolph County Nursing Home (158)  
310 W. Belmont
- SPRINGFIELD (Sangamon County)  
Americana Nursing Center of Springfield (116)  
707 N. Rutledge

- Carver Convalescent Home (61)  
1527 E. Washington St.
- Claudia's Nursing Home, Inc. (51)  
409 N. Grand Ave. East
- Colonial Cottage (4)  
116 S. State St.
- Edwards Manor Nursing Home, Inc. (60)  
1625 E. Edwards St.
- Everett McKinley Dirksen House (155)  
555 W. Carpenter
- Hamilton Nursing Home (24)  
925 N. Fifth St.
- Haven Nursing Home (72)  
2301 W. Monroe
- Homestead Convalescent Home and  
Nursing Residence (67)  
127 N. Douglas Ave.
- Myrick Nursing Home (31)  
925 S. Seventh St.
- Phillips Nursing Home, Inc. (51)  
630 N. Sixth St.
- Ramshaw Retirement Home No. 1 (47)  
631 N. Sixth St.
- Ramshaw Retirement Home No. 2 (44)  
611 N. Sixth St.
- Ridgewood Nursing Home (48)  
3400 Peoria Rd.
- Rutledge Manor Care Home, Inc. (121)  
819 N. Rutledge
- STAUNTON (Macoupin County)  
Staunton Nursing Home, Inc. (56)  
215 W. Pennsylvania St.
- STERLING (Whiteside County)  
Colonial Acres Rest Home (70)  
Rt. 2
- STOCKTON (Jo Daviess County)  
Morgan Memorial Home (27)  
501 E. Front Ave.
- STREATOR (LaSalle County)  
Edgetown Nursing Home (24)  
West Chicago St.
- Heritage Manor (57)  
1525 E. Main St.
- Star Haven Convalescent and Nursing  
Home (21)  
405 N. Wasson St.
- SULLIVAN (Moultrie County)  
East View Manor Nursing Home (52)  
Eastview Pl., Box 234
- Singiser Nursing Home (30)  
817 E. Jackson St.
- SUMNER (Lawrence County)  
Red Hills Rest Haven (96)  
Pine Lawn Addition
- SWANSEA (St. Clair County)  
Castle Haven Convalescent Center (154)  
225 Castellano Dr.
- TAYLORSRINGS (Montgomery)  
Hillsboro Nursing Home (South)  
South Route 127
- TAYLORVILLE (Christian County)  
Dexheimer Nursing Home (21)  
216 E. Franklin St.
- Johnson Nursing Home (12)  
1024 W. Park
- Meadow Manor, Inc. (98)  
Rt. 48 North
- Smith's Guest Home (40)  
305 E. Adams St.
- TINLEY PARK (Cook County)  
Kosary Nursing Home (69)  
6660 W. 147th St.
- McAllister Nursing Home No. 2 (45)  
183rd and LaVerne Ave.
- TREMONT (Tazewell County)  
Tazewell County Nursing Home (124)  
R.R. 1
- TROY (Madison County)  
Rockwood Rest Home (23)  
212 N. Powell St.
- TUSCOLA (Douglas County)  
Douglas Nightengale Manor, Inc.  
R.R. 2
- Martin Nursing Home (30)  
114 E. Daggy St.
- URBANA (Champaign County)  
Americana Nursing Center of Champaign-  
Urbana (100)  
600 N. Coler
- Champaign County Nursing Home (198)  
1701 E. Main St.
- Fontana Nursing Care Center (98)  
907 Lincoln Ave.
- Hubert Nursing Home (19)  
505 W. Green St.
- VANDALIA (Fayette County)  
Fayette County Hospital Annex (33)  
727 W. Jackson
- Fayette County Nursing Home (34)  
R.R. 3
- Ted Mangner Nursing Home, Inc. (32)  
117 S. Seventh St.
- VIENNA (Johnson County)  
Hill View Nursing Home (51)
- VILLA PARK (DuPage County)  
Acre View Nursing Home (38)  
538 S. Villa Ave.
- VIRDEN (Macoupin County)  
Miller's Nursing Home (23)  
231 E. Deane St.
- VIRGINIA (Cass County)  
Walker Nursing Home (34)  
530 E. Beardstown St.
- WARREN (Jo Daviess County)  
Daters Nursing Home (18)  
Water St.
- Lahey Nursing Home (23)  
Burnett St.
- Sunnyside Nursing Home (15)  
206 Lions St.

- WASHBURN (Woodford County)  
Washburn Nursing Home (32)  
231 Parkside Dr.
- WASHINGTON (Tazewell County)  
Washington Home (40)  
104 E. Holland St.  
Washington Nursing Center (88)  
1110 New Castle Rd.
- WATERLOO (Monroe County)  
Monroe County Nursing Home (182)  
Illinois Ave.
- WATSEKA (Iroquois County)  
Iroquois Resident Home (58)  
830 S. Fourth St.
- WAUKEGAN (Lake County)  
The Terrace Nursing Home (112)  
1615 Sunset Ave.  
Waukegan Pavilion Nursing Home, Inc. (96)  
2217 W. Washington St.
- WAVERLY (Morgan County)  
Bridges Nursing Home (18)  
200 E. State St.
- WEST CHICAGO (DuPage County)  
Hazelhurst Nursing Home, Inc. (29)  
Roosevelt Rd. and Gary Mill, Box 216  
Morton Manor Health Home (28)  
R.R. 1, Box 479
- WHEATON (DuPage County)  
DuPage Convalescent Home (288)  
O. S. 262 County Farm Rd.  
Parkway Terrace Nursing Home (69)  
219 E. Parkway Dr.  
Wheaton Health Resort, Inc. (96)  
1325 Manchester Rd.
- WHITE HALL (Greene County)  
Hill Top Haven, Inc. (39)  
R.R. 1
- WINFIELD (DuPage County)  
Abbey-Winfield Geriatric & Convalescent Home (48)  
Wynwood Rd. and Shady Way  
Zace Retirement Home (41)  
27 W. 141 Liberty St.
- WITT (Montgomery County)  
Laura-Charles Nursing Home, Inc. (34)  
Allen St.
- WOOD DALE (DuPage County)  
Wood Dale Nursing Home (70)  
140 N. Hemlock
- WOODSTOCK (McHenry County)  
New Woodstock Residence (112)  
309 McHenry Ave.  
Valley Hi Nursing Home (61)  
2406 Hartland Rd.
- YORKVILLE (Kendall County)  
Hillside Nursing and Convalescent Home, Inc. (33)  
Rt. 34 and Game Farm Rd.  
Hillside Nursing and Convalescent Home, Inc., No. 2 (35)  
Rt. 34 and Prairie Ln.
- ZION (Lake County)  
Golden Day Nursing Home (32)  
923 Shiloh Blvd.  
Parkview Nursing Home, Ltd. (70)  
1911—27th St.  
Zion Nursing Home (144)  
2561 Sheridan Rd.

## SHELTERED CARE HOMES

- ALEDO (Mercer County)  
Fortner Sheltered Care Home (36)  
1006 E. Fifth St.
- ALHAMBRA (Madison)  
Ramsey's Haven of Rest, Inc.  
Main & Warsaw
- ALTON (Madison County)  
Alby Street Sheltered Care Home (30)  
1912 Alby St.  
Burt Sheltered Care Home (29)  
1414 Milton Rd.  
Mitchell Sheltered Care Home (6)  
1800 Belle St.  
West Shelter Care Home (23)  
1914 Washington Ave.
- ANNA (Union County)  
Dodson Shelter Care Home (23)  
300 South St.  
Galbraith Shelter Care Home (17)  
223 W. Vienna St.  
Grissom Sheltered Care Home (9)  
Brady Mill Road, R.R. 1  
HS&D Sheltered Care Home (12)  
201 E. Highland St.  
Pitts Sheltered Care Home (19)  
310 E. Davie St.
- Walnut Grove Shelter Care (19)  
612 E. Davie St.
- ARROWSMITH (McLean County)  
Murrell's Guest Home (6)
- ASHLAND (Cass County)  
Burch Home (10)
- ASHMORE (Coles County)  
Ashmore Estates (42)
- ATLANTA (Logan County)  
Myrick Atlanta Shelter Care Home  
505 Chatham
- BARRY (Pike County)  
Huddleston Sheltered Care Home (8)  
Rogers St., R.R. 2
- BARTONVILLE (Peoria County)  
Martin's Sheltered Home (28)  
10 McClure Ct.
- BELLEVILLE (St. Clair County)  
Gribler Sheltered Care Home (15)  
511 S. Charles St.  
Heidelberg Retirement Home (16)  
200 Abend St.  
Jackson Shelter Care Home  
521 Borman St.  
Weier Retirement Home (28)  
5 Gundlach Pl.



- BENTON (Franklin County)  
 Cockrum Sheltered Care Home, Inc. (44)  
 1409 N. Main St.  
 Good Samaritan Sheltered Care Home (13)  
 904 E. Main St.  
 Good Shephard Shelter Care Home (14)  
 403 N. Main St.  
 Higgerson's Home (14)  
 209 N. Eighth St.  
 Mary Grace Sheltered Care Home (12)  
 112 Smith St.  
 Rend Lake Shelter Care Home  
 314½ South Main St.  
 Severin Sheltered Care Home (13)  
 105 Mill St.  
 Shady Rest Sheltered Care (18)  
 114 E. Webster St.  
 Wertz's Sheltered Care Home (13)  
 217 Pope St.
- BETHANY (Moultrie County)  
 White Shelter Care Home (19)  
 513 E. Main St.
- BLOOMINGTON (McLean County)  
 Prairie Sheltered Care Home (12)  
 1108 N. Prairie St.  
 Johnson's Sheltered Care Home (19)  
 412 N. Roosevelt Ave.  
 Hanson Sheltered Care Home (17)  
 909 S. Center St.  
 Millers Shelter Care Home (10)  
 903 W. Mullberry St.  
 Rusk Haven Shelter Home (42)  
 102 Greenwood Ave.
- BRADFORD (Stark County)  
 Bradford Home (23)  
 214 E. Main St.
- BUNKER HILL (Macoupin County)  
 Hammond Shelter Care Home (26)  
 512 S. Franklin
- BUSHNELL (McDonough County)  
 Daly's Sheltered Care Home  
 554 Rile St.  
 Daly's Golden Age Home (17)  
 257 E. Hail St.
- CAIRO (Alexander County)  
 Brown Sheltered Care Home  
 411 Seventh St.
- CAMBRIDGE (Henry County)  
 Pine Lodge Home (17)  
 112 E. Center St.
- CANTON (Fulton County)  
 Sunset Home (47)  
 135 S. First Avenue  
 Sunset Sheltered Care Home No. 2 (52)  
 129 S. First Ave.
- CARBONDALE (Jackson County)  
 Suburban Dorm Shelter Care Home (40)  
 R.R. 6, P.O. Box 897
- CARROLLTON (Greene County)  
 Mt. Gilead Shelter Care Home (28)  
 R.R. 2
- CARTHAGE (Hancock County)  
 Welborn Shelter Care Home No. 2 (17)  
 140 Main St.
- CASEY (Clark County)  
 Rude's Goodwill Shelter Home (12)  
 110 E. Monroe St.
- CENTRALIA (Clinton County)  
 Brookside Manor, Inc. (54)  
 2000 W. Broadway
- CENTRALIA (Marion County)  
 Brewer Shelter Care Home (16)  
 603 N. Walnut St.  
 Centralia Friendship House, Inc. (58)  
 1000 E. McCord St.
- CHAMPAIGN (Champaign County)  
 LaDow Sheltered Care Home (17)  
 406 S. Prairie St.  
 Pleasant Manor (15)  
 211 E. Clark St.
- CHARLESTON (Coles County)  
 Rennels Sheltered Care Home (21)  
 216 Fifth St.  
 Coles Retirement Center, Inc.  
 1501 Eighteenth St.  
 Teaters Sheltered Care Home (32)  
 Fifth and Jackson Sts.  
 Young Sheltered Care Home (18)  
 763 Tenth St.
- CHEBANSE (Iroquois County)  
 Morgan Manor (10)  
 243 First South St.
- CHENOA (McLean County)  
 McBroom's Rose Lawn Sheltered Care Home  
 No. 2 (20)  
 324 Weir St.
- CHESTER (Randolph County)  
 Padgett's Pot-A-Pourri Rest Home (38)  
 647 State St.
- CHICAGO (Cook County)  
 Belden Manor  
 1200 W. Belden Ave.  
 Boulevard Home (19)  
 4533 W. Washington Blvd.  
 Continental Medical Management Corp. (115)  
 5148 S. Prairie Ave.  
 Hamlin House (435)  
 6 N. Hamlin  
 Jewish Peoples Convalescent Home (37)  
 6512 N. California Ave.  
 Kraus Home, Inc. (27)  
 1620 W. Chase Ave.
- CLINTON (DeWitt County)  
 Burns Sheltered Care (5)  
 930 N. George
- COAL VALLEY (Rock Island County)  
 Oak Glen Home  
 R.R. 1
- COBDEN (Union County)  
 Tripp Sheltered Care Home (30)  
 Box 323  
 Village Sheltered Care Home

**COLLINSVILLE** (Madison County)  
 Butler Home (16)  
 413 Vandalia St.  
**COULTERVILLE** (Randolph County)  
 Coulterville Sheltered Care Home (21)  
 Seventh and Cedar Sts.  
**DALLAS CITY** (Henderson County)  
 Welborn Sheltered Care Home (10)  
 69 E. Main St.  
**DANVERS** (McLean County)  
 Holman Shelter Care Home (22)  
 300 E. Exchange St.  
**DANVILLE** (Vermilion County)  
 Danville Community Sheltered Care Home (10)  
 431 South Street  
 Golden Years Sheltered Care Home  
 1118 Franklin St.  
 Homelike Care  
 614 North Bowman Ave.  
**DECATUR** (Macon County)  
 Anna B. Millikin Home (30)  
 302 S. Union Street  
 Farrar Sheltered Care Home (14)  
 1860 N. Broadway St.  
 Gladville Home (12)  
 1013 W. Wood St.  
 Lindsey Rest Home (7)  
 737 W. Wood St.  
**DONGOLA** (Union County)  
 McCommons Sheltered Care Home  
 R.R. 2, P.O. Box 246  
 Keller Sheltered Care Home (27)  
 Box 8  
 Keller Sheltered Care Home No. 2  
 109 Cross St.  
**DUQUOIN** (Perry County)  
 Fairview Residential Center  
 602 E. Jackson St.  
 Miller Sheltered Care Home (18)  
 24 S. Line St.  
**EAST PEORIA** (Tazewell County)  
 Good Samaritan Shelter Care Home  
 1910 Springfield Road  
**EAST ST. LOUIS** (St. Clair County)  
 Butler Sheltered Care Home No. 2  
 1121 St. Clair Avenue  
 Carr Sheltered Care Home (9)  
 3112 Bond St.  
 Park Retirement Home No. 2 (14)  
 2245 North Fifth St.  
 Popejoy's Retirement Home (27)  
 1504 Illinois Ave.  
**EFFINGHAM** (Effingham County)  
 Golden Years Sheltered Care Home  
 308 South Fifth St.  
 Ireland Sheltered Care Home (7)  
 111 Forest St.  
 Marks Sheltered Care Home (22)  
 500 Clinton Ave.  
**ELDORADO** (Saline County)  
 Eldor-Lee Manor  
 1104 Walnut St.  
 Murray Hotel (34)  
 900 Fifth St.  
**ELGIN** (Kane County)  
 The Oliver Annex (11)  
 364 St. Charles St.  
**EL PASO** (Woodford County)  
 Elderly Citizens Home (24)  
 Main St.  
 Tobien Elderly Citizens Home (27)  
 408 First St.—Elmwood Court  
**ENFIELD** (White County)  
 Fields Shelter Care Home (20)  
 W. Main St.  
**FAIRFIELD** (Wayne County)  
 Fair Haven Shelter Care Home (9)  
 507 W. Elm St.  
**FLORA** (Clay County)  
 Bramson Manor Shelter Care Home  
 East 12th Street  
 Cattengaim Shelter Care (8)  
 215 W. North Ave.  
 Ferguson Sheltered Care Home (6)  
 520 W. North Ave.  
 Raber Sheltered Care Home (6)  
 409 E. Third St.  
**GALESBURG** (Knox County)  
 Barre's Sheltered Care Home (13)  
 1179 E. Main St.  
 The Evergreens (14)  
 1188 W. Main St.  
 Harvey Sheltered Care Home  
 774 North Broad St.  
 Lee's Sheltered Care Home (14)  
 736 N. Kellogg St.  
 Schrader Shelter Care Home (15)  
 484 N. Cherry St.  
**GALVA** (Henry County)  
 Galva Manor (35)  
 309 N. First St.  
**GEORGETOWN** (Vermilion County)  
 "We Care" Shelter Care  
 507 East 13th St.  
**GODFREY** (Madison County)  
 Beverly Farm Foundation  
 Humbert Road  
**GOLCONDA** (Pope County)  
 Riverside Sheltered Care Home (10)  
 Monroe St.  
 Rose View Sheltered Care Home (10)  
 Washington and Harrison Sts.  
**GRAYVILLE** (White County)  
 Hillcrest Home (13)  
 320 W. South St.  
**GREENFIELD** (Greene County)  
 Hospitality House Sheltered Care (21)  
 210 Walnut St.  
**GREENUP** (Cumberland County)  
 Peters Shelter Care Home (32)  
 308 N. Kentucky St.  
**GREENVILLE** (Bond County)  
 Horsfall Sheltered Care Home (52)  
 201 S. Second St.

- GRIDLEY (McLean County)  
Gridley Shelter Care Home (21)  
202 W. 6th St.
- HARDIN (Calhoun County)  
Hardin Sheltered Care Home (14)  
County Road St.
- HARRISBURG (Saline County)  
Saline Valley, Inc.  
200 South Land
- HARVEY (Cook County)  
Dixie Manor Sheltered Care (19)  
15535 Dixie Highway  
Halsted Manor (16)  
16048 South Halsted  
Kenniebrew Home (16)  
14816 S. Marshfield  
Kenniebrew Manor (10)  
14812 S. Marshfield  
Liberty House (16)  
16044 S. Halsted St.  
Parkside Manor (16)  
16052 S. Halsted St.  
South Suburban Manor (14)  
16128 S. Halsted St.
- HAVANA (Mason County)  
Oest Sheltered Care (15)  
121 S. Pearl St.
- HERRIN (Williamson County)  
Mattingly Sheltered Care Home (19)  
700 N. 14th St.  
Oak Park Sheltered Care Home  
1900 N. Park Avenue  
Park Avenue Sheltered Care Home (33)  
Rt. 148, P.O. Box 68
- HEYWORTH (McLean County)  
Lush Sheltered Care Home (15)  
303 E. Main St.
- HILLSBORO (Montgomery County)  
Hillsboro Shelter Care Home  
628 S. Main St.
- HOPEDALE (Tazewell County)  
Hopedale House (50)
- HUTSONVILLE (Crawford County)  
The Heritage  
207 Wood Lane
- INA (Jefferson County)  
Underwood Sheltered Care Home (15)  
3 Elm Street
- IRVING (Montgomery County)  
Country View Manor (57)
- JACKSONVILLE (Morgan County)  
Bell Sheltered Care Home (21)  
602 Jordan St.  
Blue Sheltered Care Home (6)  
506 W. Morton Ave.  
Hoots Rest Home (16)  
717 E. Douglas St.  
Parker Sheltered Care Home (20)  
203 W. Beecher Ave.  
Rosedale Sheltered Care Home (16)  
220 Brown St.
- Smith-Tucker Sheltered Care Home No. 1 (26)  
606 N. Church St.
- Smith-Tucker Sheltered Care Home No. 2 (14)  
616 N. Church St.
- JERSEYVILLE (Jersey County)  
Alma's Shelter Care Home (26)  
301 W. Pine St.  
Stark's Sheltered Care Home (20)  
600 N. Liberty St.
- JOHNSTON CITY (Williamson County)  
Cazaleen's Sheltered Care Home (13)  
207 E. Fifth St., Box 163  
Maple House Shelter Care (23)  
207 E. Third St.  
Maple House Sheltered Care Home No. 2 (23)  
205 E. 3rd St.  
Nellie Ernfeld Home (31)  
R. R. 1
- JONESBORO (Union County)  
City Sheltered Care Home (18)  
201 Broad St.  
Gibbs and McRaven Sheltered Care Home (6)  
204 S. Pecan St.  
Henard Sheltered Care Home (17)  
204 S. Main St.  
Spurlock Shelter Care Home (36)  
Jonesboro Square  
Travis Sheltered Care Home  
107 South Main St.
- KAMPSVILLE (Calhoun County)  
Smith Sheltered Care Home (12)
- KANKAKEE (Kankakee County)  
Bethel Shelter Home (11)  
556 E. Oak St.  
Geeding Shelter Home (16)  
139 S. Greenwood Ave.  
J. C. Good Shelter Home (16)  
195 N. Entrance Ave.  
Oaklawn Home (16)  
191 N. Washington Ave.
- KEWANEE (Henry County)  
Kewanee Manor (22)  
218 S. Tremont St.  
St. Francis Continuing Care Home  
513 Elliot Street
- LaHARPE (Hancock County)  
Gillett Home No. 2 (16)  
W. Main St.  
Hoosier Sheltered Care Home (15)  
114 Archer Ave.
- LAKE ZURICH (Lake County)  
Mount St. Joseph (158)  
Route 3, Box 261
- LeROY (McLean County)  
LeRoy Home (24)  
902 N. Mill St.
- LEXINGTON (McLean County)  
McBrooms Rose Lawn Shelter Care Home  
No. 1 (22)  
207 N. Elm St.  
Three Oaks Sheltered Care Home (20)  
306 W. South St.



LOUISVILLE (Clay County)  
 Twilight Haven (18)  
 Hiram St. & Rt. 45  
 Hill Crest Sheltered Care Home  
 Route 45 & Chestnut

LOVINGTON (Moultrie County)  
 Gaddis Shelter Care Home, Inc. (26)  
 240 E. State St.  
 Gaddis Sheltered Care Home II  
 134 N. Center St.

MADISON (Madison County)  
 Madison Sheltered Care Home (21)  
 1521 - Second St.

MARION (Williamson County)  
 Lee Manor (30)  
 1305 W. Main St.  
 Marion Manor  
 1101 North Madison

MARSHALL (Clark County)  
 Dunkel Home (20)  
 325 S. Sixth St.  
 Marshall Christian Hotel (34)  
 805 Archer Ave.

MARTINSVILLE (Clark County)  
 Glendening Home (24)  
 25 S. Washington St.

McHENRY (McHenry County)  
 Shan Gra-La Sheltered Care Home (8)  
 3820 W. Idyldell Rd.

McLEANSBORO (Hamilton County)  
 McLean Manor Sheltered Care (35)  
 104 W. Market St.  
 McLeansboro Shelter Care Home (37)  
 205 E. Cherry St.

METROPOLIS (Massac County)  
 Care Homes, Inc. (33)  
 205 Metropolis St.  
 Senior Citizens Retirement Home (27)  
 308 W. Third St.  
 Wallace Sheltered Care Home (17)  
 202 Metropolis St.

MILFORD (Iroquois County)  
 Golden Jubilee Home (13)  
 28 S. West Ave.

MINONK (Woodford County)  
 Minonk Manor, Inc. (22)  
 221 Locust St.

MOLINE (Rock Island County)  
 Hensley Home (13)  
 1111 Fifteenth St.  
 Kincaide Sheltered Care Home (12)  
 2602 Sixth Ave.  
 Paul's Boarding Home (14)  
 849 Fifteenth St.

MORTON (Tazewell County)  
 Morton Home (20)  
 424 N. Main St.

MT. CARMEL (Wabash County)  
 Chestnut Sheltered Care Home (24)  
 218 Chestnut  
 Ladies Lodge (21)  
 318 W. Second St.

Shurtleff Annex Sheltered Care Home (24)  
 416 Plum St.  
 Shurtleff Shelter Care Cottage (10)  
 429 E. Fifth St.

MT. STERLING (Brown County)  
 Mt. Sterling Sheltered Care (16)  
 117 E. South St.

MT. VERNON (Jefferson County)  
 Hearthside Sheltered Care Home (21)  
 318 N. Ninth St.  
 Hickory View Manor, Inc. (60)  
 5 Doctors Park Rd.  
 Maple Grove Sheltered Care Homes  
 1304 Main St.

MUNDELEIN (Lake County)  
 Riverside Manor (27)  
 Route 1

MURPHYSBORO (Jackson County)  
 River Bend Manor (66)  
 1501 Shomaker Dr.

NEWTON (Jasper County)  
 DuMont Sheltered Care Home (22)  
 438 S. Lafayette St.

NOBLE (Richland County)  
 H. & M. Pleasant Center  
 148 West North Ave.

NORTHBROOK (Cook County)  
 Chateau Home  
 3410 Milwaukee Ave.

OBLONG (Crawford County)  
 Fouty's Sheltered Care Home (15)  
 507 S. Garfield St.  
 Hart Sheltered Care (14)  
 403 N. Range St.

ODELL (Livingston County)  
 The Odell Shelter, Inc. (25)  
 17 Henry St.

ODIN (Marion County)  
 Risinger Sheltered Care  
 Box 186

O'FALLON (St. Clair County)  
 Andricks Shelter Care (10)  
 135 Main St.

OLD MARISSA (St. Clair County)  
 Old Marissa Sheltered Care Home (17)

OLNEY (Richland County)  
 Braden Sheltered Care (9)  
 230 E. North Ave.  
 Colonial Manor Sheltered Care (31)  
 327 S. Morgan St.  
 Golden Years Sheltered Care  
 502 South Fair  
 Marks Sunset Manor (29)  
 1044 Whittle  
 Miller Sheltered Care House (15)  
 103 E. Lafayette St.  
 Rachel Moore Shelter Care (6)  
 413 S. Morgan

ONARGA (Iroquois County)  
 Jones Sheltered Care (11)  
 317 N. Walnut

OQUAWKA (Henderson County)  
     Oquawka Shelter Home (17)  
 OTTAWA (LaSalle County)  
     Susie H. Moore Sheltered Care Home  
         627 Third Avenue  
 PALMYRA (Macoupin County)  
     Light House Shelter (12)  
 PARIS (Edgar County)  
     Colonial Home (6)  
         623 N. Central Ave.  
     Hefner Shelter Care (6)  
         210 Chestnut St.  
     Sanders Sheltered Care Home (13)  
         813 Tenbrook  
 PAW PAW (Lee County)  
     Pfeiffer Sheltered Care Home (10)  
 PEKIN (Tazewell County)  
     B. J. Perino Shelter Care Home, Inc. (54)  
         601-603 Prince St.  
 PEORIA (Peoria County)  
     Senior Citizens Sheltered Care Home (11)  
         302 W. Third St.  
     Waldo Home (45)  
         405 N. Perry  
 PERU (LaSalle County)  
     Hillview Manor (12)  
         2106 Market St.  
 PITTSFIELD (Pike County)  
     Pittsfield Sheltered Care House (10)  
         411 W. Washington St.  
 PLANO (Kendall County)  
     Wesley Haven, Inc. (20)  
         218 N. Center  
 PLYMOUTH (Hancock County)  
     Sapp's Sheltered Care Home (12)  
     Thomas Sheltered Care Home (14)  
         Box 323  
 QUINCY (Adams County)  
     Bacon Sheltered Care Home (9)  
         1435 N. Fifth St.  
     Beever Sheltered Care Home (26)  
         327 Elm St.  
     Christian Shelticenter, Inc.  
         1340 North Tenth St.  
     Frances Shelter Care Home (17)  
         431 Locust St.  
     Park Manor, Inc.  
         1900 Harrison  
 REDMAN (Edgar County)  
     Carter's Shelter Care Home, Inc.  
 ROCHELLE (Ogle County)  
     Joyce Old Folks Home (16)  
         609 N. Sixth St.  
 ROCK FALLS (Whiteside County)  
     Riverview Haven (16)  
         308 E. 2nd St.  
 ROCKFORD (Winnebago County)  
     Bethany House (14)  
         412 N. Court St.  
     Park View Home (29)  
         408 N. Horsman St.  
 ROODHOUSE (Greene County)  
     Dameron Shelter Care Home (15)  
         114 E. Palm St.  
 ROSEVILLE (Warren County)  
     Roseville Sheltered Care Home (18)  
         North Main St.  
 ROYALTON (Franklin County)  
     Village Manor Shelter Care Home  
         106 Royal St.  
 RUSHVILLE (Schuyler County)  
     Lacey's Care Home (18)  
         239 W. Clay St.  
 ST. CHARLES (Kane County)  
     Valley-Haven (24)  
         309 S. Sixth Ave.  
 ST. JACOB (Madison County)  
     Nolen Sheltered Care Home (25)  
         R. R. 1  
 SALEM (Marion County)  
     Salem Sheltered Care Home (19)  
         521 E. Church St.  
     Bryan Manor Shelter Care Home  
         Route 37 North, P.O. Box 328  
     Franklin Home  
         400 South Franklin St.  
 SANDOVAL (Marion County)  
     Finn's Sheltered Care Home (18)  
         W. North Second St.  
 SAYBROOK (McLean County)  
     Maplebrook (15)  
         Main St.  
 SESSER (Franklin County)  
     Nixt Sheltered Care Home (4)  
         303 W. Mathew  
 SHELDON (Iroquois County)  
     Sheldon Sheltered Home (40)  
         170 W. Concord Street  
 SIMPSON (Pope County)  
     Shawnee Shelter Care (14)  
         R. R. 2  
 SPARTA (Randolph County)  
     Kirsby Shelter Home (22)  
         411 S. St. Louis St.  
 SPRINGFIELD (Sangamon County)  
     Lane Bryant Retirement Home (19)  
         1712 E. Washington St.  
     Myrick's Sheltered Care Home  
         2205 E. Capitol St.  
     Springfield Half-Way House, Inc. (24)  
         1010 S. Second St.  
     Sunshine Guest Home (16)  
         607 S. Fifth St.  
     Tomlin Retirement Home (12)  
         609 N. Fourth St.  
 STOCKTON (Jo Daviess County)  
     Brog's Sheltered Care Haven (13)  
         205 E. Benton St.  
 STREATOR (LaSalle County)  
     Hillview Sheltered Care Home (18)  
         518 S. Bloomington St.

- SULLIVAN (Moultrie County)  
Beals Sheltered Care Home (28)  
13 S. McClellan St.
- SUMNER (Lawrence County)  
Pine Lawn Manor, Inc.  
P.O. Box 186
- SYCAMORE (DeKalb County)  
The Driscoll Home (15)  
309 N. California
- TALLULA (Menard County)  
Garden View (13)  
N. Ewing
- TILTON (Vermilion County)  
Mrs. Etta R. Wangler Anderson Sheltered Care Home (7)  
605 E. Fifth St.  
Smoot Memorial Home (8)  
215 W. Sixth St.
- TOLEDO (Cumberland County)  
Homestead Shelter Care Home  
R.R. #2
- TUSCOLA (Douglas County)  
Shangri-La Shelter Care (19)  
505 S. Main St.  
White House Shelter Care  
Route 36 East
- URBANA (Champaign County)  
Clark Sheltered Care Home (17)  
811 W. Oregon St.  
Lustig Sheltered Care Home (17)  
904 W. Clark St.
- VANDALIA (Fayette County)  
The Heritage House (44)  
Rt. 185 West  
Sunnydale Acres  
1500 W. St. Louis Ave.
- VERGENNES (Jackson County)  
Johnson's Sheltered Care Home
- VIENNA (Johnson County)  
Mount Shelter Care Home  
R.R. 2
- VIRGINIA (Cass County)  
Virginia Sheltered Care Home (18)  
132 E. Illini St.
- WARSAW (Hancock County)  
Carlson Sheltered Care Home (22)  
150 Main St.
- WASHINGTON PARK (St. Clair County)  
Park Retirement Home No. 1 (33)  
2246 N. 57th, P.O. East St. Louis
- WATSEKA (Iroquois County)  
Pleasant Lodge (28)  
590 E. Grant St.
- WAUKEGAN (Lake County)  
Marseilles Retirement Home, Inc. (28)  
604 N. Genesee St.
- WAVERLY (Morgan County)  
Witt Sheltered Care Home (20)  
405 S. Miller St.
- WELLINGTON (Iroquois County)  
Highfill Sheltered Care Home  
Box 7, East Main St.
- WEST FRANKFORT (Franklin County)  
Clay's Sheltered Care Home (7)  
609 S. Monroe  
Peacock Sheltered Care Home (19)  
309 W. Oak St.  
Rosehill Sheltered Care Home  
R.R. 1, Box 66  
Smith Sheltered Care Home (15)  
512 S. Cherry St.  
Fleck Sheltered Care Home (7)  
523 S. Emma St.
- WEST SALEM (Edwards County)  
Golden Acres, Inc. (33)
- WHEATON (DuPage County)  
Tall Tree Guest Home (16)  
R. R. 1, Box 34
- WHITE HALL (Greene County)  
Elliott Sheltered Care Home (14)  
601 N. Main St.  
Ford Sheltered Care Home (14)  
535 N. Main St.  
Powell Sheltered Care Home (7)  
144 E. Lincoln St.  
Shanahan Sheltered Care Home (10)  
431 Centennial St.
- YORKVILLE (Kendall County)  
Himes Sheltered Care Home (11)  
609 N. Bridge St.
- ZION (Lake County)  
Robbins Home (9)  
3220 Emmans Ave.

## HOMES FOR THE AGED

In this section, the following symbols are used:  
A—sheltered care facilities, B—nursing care facilities, and C—special geriatric facilities.

- ALHAMBRA (Madison County)  
Hitz Memorial Home—(AB-25)  
Belle St.
- ALTON (Madison County)  
The Loretto Home—(A-60)  
417 Prospect St.
- ARLINGTON HEIGHTS (Cook County)  
Lutheran Home and Service for the Aged (AB-203)  
800 W. Oakton St.
- AURORA (Kane County)  
Jennings Terrace—(AB-106)  
275 S. LaSalle St.  
Sunnymere, Inc.—(AB-48)  
925 Sixth Ave.
- BELLEVILLE (St. Clair County)  
Meredith Memorial Home—(A-85)  
16 S. Illinois St.  
St. Paul's Home—(AB-98)  
1021 W. "E" St.



- BENSENVILLE** (DuPage County)  
 Bensenville Home Society—(AB-120)  
 York and Memorial Dr.
- BROOKFIELD** (Cook County)  
 The British Home—(AB-90)  
 31st and McCormick Ave.
- CANTON** (Fulton County)  
 Nancy and Ann Kelley Home for the Aged—(A-10)  
 344 W. Chestnut St.
- CHAMPAIGN** (Champaign County)  
 The Garwood Home—(A-29)  
 1515 N. Market St.
- CHESTER** (Randolph County)  
 St. Ann's Home—(ABC-45)  
 770 State St.
- CHICAGO** (Cook County)  
 Augustana Home for the Aged—(ABC-140)  
 7540 Stony Island Ave.  
 Bethany Home—(ABC-415)  
 5015 N. Paulina St.  
 Bohemian Home for the Aged—(AB-150)  
 5061 N. Pulaski Rd.  
 Chicago Holland Home for the Aged—(A-140)  
 240 W. 107th Pl.  
 Church Home for Aged Persons—(AB-90)  
 5435-45 Ingleside Ave.  
 Cosmopolitan Community Home—(A-26)  
 51 E. 53rd St.  
 Covenant Home—(AB-101)  
 2725 W. Foster Ave.  
 Drexel Home, Inc.—(ABC-220)  
 6140 Drexel Ave.  
 Fridhem Baptist Home—(AB-95)  
 11404 S. Bell Ave.  
 George J. Goldman Memorial Home for the Jewish Aged—(AB-37)  
 1152 W. Farwell Ave.  
 Home for the Association of Jewish Blind (A-43)  
 3525 W. Foster Ave.  
 Jane Dent Home—(A-22)  
 4430-32 Vincennes Ave.  
 Jewish Home for the Aged—(ABC-286)  
 1648 S. Albany Ave.  
 Methodist Old Peoples Home—(AB-191)  
 1415 Foster Ave.  
 Northwest Home for the Aged—(AB-52)  
 2201 N. Sacramento Ave.  
 Norwegian Lutheran Bethesda Home (AB-150)  
 2833 N. Nordica Ave.  
 Norwood Park Home—(AB-140)  
 6016 N. Nina Ave.  
 The Old People's Home of the City of Chicago—(AB-125)  
 909 Foster Ave.  
 Park View Home—(ABC-142)  
 1401 N. California Ave.  
 Sacred Heart Home—(AB-200)  
 1550 S. Albany Ave.
- St. Augustine—(AB-130)  
 2358 N. Sheffield Ave.
- St. Joseph's Home for the Aged—(AB-175)  
 2650 N. Ridgeway Ave.
- St. Paul's House—(A-70)  
 3831 N. Mozart St.
- Selfhelp Home for the Aged—(AB-42)  
 4941 S. Drexel Blvd.
- Society for the Danish Old People's Home (AB-89)  
 5656 N. Newcastle Ave.
- Washington and Jane Smith Home—(AB-200)  
 2340 W. 113th Pl.
- DANVILLE** (Vermilion County)  
 Webster Memorial Home—(A-11)  
 903 N. Logan Ave.
- ELBURN** (Kane County)  
 Fellowship Deaconry—(A-11)  
 526 N. Main St.
- ELGIN** (Kane County)  
 Oak Crest Residence—(AB-43)  
 204 S. State St.
- EUREKA** (Woodford County)  
 Apostolic Christian Home at Eureka (AB-60)  
 610 W. Cruger St.
- Maple Lawn Homes—(AB-96)  
 Box 37, R.R. 2
- EVANSTON** (Cook County)  
 Alonzo Mather Aged Ladies Home (AB-219)  
 1615 Hinman Ave.
- The Georgian, Division of Methodist Old Peoples Home—(AB-245)  
 422 Davis St.
- Homecrest Foundation—(A-50)  
 1430 Chicago Ave.
- James C. King Home for Old Men (AB-84)  
 1555 Oak Ave.
- Lake Crest Villa—(A-32)  
 2601 Central St.
- Pioneer Place—(AB-113)  
 2320 Pioneer Rd.
- Presbyterian Home—(ABC-303)  
 3200 Grant St.
- FAIRBURY** (Livingston County)  
 Fairview Haven, Inc.—(AB-43)  
 605-609 N. Fourth
- FLANAGAN** (Livingston County)  
 Good Samaritan Home of Flanagan  
 Box 308
- FOREST PARK** (Cook County)  
 Altenheim (German Old Peoples Home) (AB-265)  
 7824 Madison St.
- FREEPORT** (Stephenson County)  
 Freeport-Bensenville Home—(A-20)  
 822 W. Stephenson St.
- Park View Home—(A-26)  
 1234 South Park Blvd.

- St. Joseph Home for the Aged—(AB-118)  
649 E. Jefferson St.
- GIRARD (Macoupin County)  
The Home—(A-48)  
1020 West North St.
- GLENVIEW (Cook County)  
Maryhaven Village for Aged and Blind  
(AB-166)  
1700 E. Lake Ave.
- GOLDEN (Adams County)  
Golden Good Shepherd Home, Inc.—(AB-48)
- HIGHLAND (Madison County)  
Highland Home—(A-48)  
1600 Walnut St.
- HIGHLAND PARK (Lake County)  
Villa St. Cyril—(ABC-89)  
1111 St. Johns Ave.
- HINSDALE (Cook County)  
King-Bruwaert House—(AB-101)  
6101 County Line Rd.
- HINSDALE (DuPage County)  
Godair Home—(AB-53)  
6259 S. Madison St.
- JACKSONVILLE (Morgan County)  
Illinois Christian Home, Inc.—(AB-110)  
873 Grove St.
- JOLIET (Will County)  
Our Lady of Angels Retirement Home  
(ABC-100)  
1201 Wyoming Ave.  
St. Patrick Residence—(ABC-203)  
22 E. Clinton St.  
Salem Home for the Aged—(ABC-82)  
1313 Rowell Ave.
- JUSTICE (Cook County)  
Rosary Hill Convalescent Home—(AB-75)  
9000 W. 81st St.
- KEWANEE (Henry County)  
The Whiting Home—(A-10)  
320 S. Chestnut St.
- KNOXVILLE (Knox County)  
Illinois P.E.O. Home—(A-35)  
415 E. Main St.
- LaGRANGE PARK (Cook County)  
Plymouth Place—(AB-273)  
315 N. LaGrange Rd.
- LAKE VILLA (Lake County)  
American Aid and Old Peoples Home  
Society—(A-18)  
259 W. Grand Ave.
- LAWRENCEVILLE (Lawrence County)  
The Methodist Home—(ABC-243)  
1601 S. Sixteenth St.
- LEMONT (Cook County)  
Holy Family Villa—(AB-112)  
123rd St.  
Mother Theresa Home—(AB-54)  
1270 Main St.
- LINCOLN (Logan County)  
Deaconess Memorial Home Annex—(A-20)  
315 Eighth St.
- MACOMB (McDonough County)  
Everly House—(A-38)  
811 S. Lafayette St.
- MACON (Macon County)  
Eastern Star Home at Macon—(AB-111)
- MATTOON (Coles County)  
Illinois I.O.O.F. Old Folk's Home—(AB-225)  
E. Lafayette St.
- MAYWOOD (Cook County)  
Baptist Retirement Home—(AB-229)  
316 Randolph St.  
Maywood Home for Soldiers Widows—(A-32)  
224 N. First Ave.
- MEADOWS (McLean County)  
Meadows Mennonite Home—(AB-66)
- MENDOTA (LaSalle County)  
Mendota Lutheran Home—(AB-42)  
500 Sixth St.
- MORRISON (Whiteside County)  
Resthave Home of Whiteside County—(A-27)  
Maple Ave.
- MORTON GROVE (Cook County)  
Bethany Terrace Retirement and Nursing  
Home—(AB-252)  
8425 N. Waukegan Rd.
- MT. CARROLL (Carroll County)  
Caroline Mark Home—(A-16)  
222 E. Lincoln St.
- MT. MORRIS (Ogle County)  
Pinecrest Manor—(AB-122)  
414 S. McKendrie Ave.
- NEW ATHENS (St. Clair County)  
New Athens Home—(AB-36)  
203 S. Johnson St.
- NILES (Cook County)  
St. Andrew Home for the Aged—(AB-225)  
7000 N. Newark Ave.  
St. Benedict's Home for the Aged—(AB-52)  
6930 W. Touhy Ave.
- NORMAL (McLean County)  
Shamel Manor—(A-100)  
509 N. Adelaide
- NORRIDGE (Cook County)  
Central Baptist Home for the Aged—(AB-94)  
7901 W. Lawrence Ave.
- NORTHLAKE (Cook County)  
Villa Scalabrini—(AB-88)  
Wolf Rd. and Palmer St.
- NORTH RIVERSIDE (Cook County)  
Scottish Old Peoples Home—(AB-50)  
28th St. and DesPlaines Rd.
- OTTAWA (LaSalle County)  
Cora J. Pope Home—(A-14)  
116 W. Prospect St.  
Pleasant View Luther Home—(ABC-146)  
505 College Ave.
- PALATINE (Cook County)  
St. Joseph's Home for the Elderly—(AB-250)  
80 W. Baldwin Rd.
- PARK RIDGE (Cook County)  
St. Matthew Lutheran Home—(ABC-90)  
1601 N. Western Ave.

- PAXTON** (Ford County)  
 Illinois Knight Templar Home for the  
 Aged Infirm—(AB-29)  
 706 S. Washington St.
- PEORIA** (Peoria County)  
 Apostolic Christian Home—(A-32)  
 7023 Northeast Skyline Dr.  
 Christian Buehler Memorial Home—(AB-223)  
 3415 N. Sheridan Rd.  
 Guyer Memorial Home—(A-18)  
 201 W. Columbia Terr.  
 John C. Proctor Endowment Home—(AB-224)  
 1301 N.E. Glendale Ave.  
 St. Joseph's Home for the Aged—(AB-200)  
 2223 W. Heading Ave.
- PEOTONE** (Will County)  
 Peotone Bensenville Home—(AB-29)  
 Wood and West Sts.
- PONTIAC** (Livingston County)  
 Evenglow Lodge—(ABC-190)  
 201 E. Washington St.  
 Humiston Haven—(AB-74)  
 300 W. Lowell St.
- PRICETON** (Bureau County)  
 Adeline E. Prouty Home—(A-79)  
 508 Park Ave. East
- QUINCY** (Adams County)  
 Anna Brown Home for the Aged—(AB-35)  
 1507 N. Fifth St.  
 Good Samaritan Home—(AB-109)  
 2130 Harrison St.  
 Methodist Sunset Home—(ABC-144)  
 418 Washington St.
- ROCKFORD** (Winnebago County)  
 Eastern Star Home of Rockford—(AB-99)  
 2400 S. Main St.  
 Fairhaven Christian Home—(AB-87)  
 3470 N. Alpine Rd.  
 P. A. Peterson Home—(AB-25)  
 1301 Parkview Ave.
- Wesley Willows, a Methodist Retirement  
 Home—(ABC-244)  
 4141 N. Rockton Ave.  
 Winnebago Home for the Aged—(AB-45)  
 Box 2, Safford Rd.
- ROCK ISLAND** (Rock Island County)  
 Cleveland Home for the King's Daughters  
 of Illinois, Inc.—(A-24)  
 805 Nineteenth St.  
 Huber Memorial Home—(A-23)  
 1000—30th St.
- SPRINGFIELD** (Sangamon County)  
 Carrie Post King's Daughters Home  
 for Women—(A-38)  
 541 Black Ave.  
 Illinois Presbyterian Home, Inc.—(A-61)  
 W. Lawrence at Chatham Rd.  
 Mary Bryant Home for the Blind—(A-48)  
 1100 S. Fifth St.  
 St. Joseph's Home for the Aged—(AB-154)  
 S. Sixth Street Rd.
- SULLIVAN** (Moultrie County)  
 Illinois Masonic Home—(AB-310)  
 Rt. 121 East  
 Titus Memorial Presbyterian Home—(A-11)  
 513 N. Worth St.
- TECHNY** (Cook County)  
 St. Ann's Home and Infirmary—(ABC-200)  
 Waukegan Rd.
- VIRDEN** (Macoupin County)  
 Mothers' Memorial Baptist Home—(AB-27)  
 402 W. Loud St.
- WHEELING** (Cook County)  
 Addolorata Villa—(AB-112)  
 Hwy. 83, McHenry Rd.
- WILMETTE** (Cook County)  
 Baha'i Home—(A-20)  
 401 Greenleaf Ave.  
 Maryhaven, Inc.—(AB-113)  
 2228 Beechwood Ave.
- WOODSTOCK** (McHenry County)  
 Sunset Manor, Inc.—(AB-54)  
 920 Seminary Ave.

## EXTENDED CARE FACILITIES

The facilities listed below have been surveyed by the Illinois Department of Public Health and certified by the U.S. Department of Health, Education, and Welfare as Extended Care Facilities for Medicare beneficiaries, as of Aug. 1, 1969. The number of certified beds within the facility is indicated.

### ABINGDON

Abingdon Nursing Home (74)

### ALTON

Eunice C. Smith Home (64)

### ANNA

Union County Hospital (19)

### ARTHUR

The Arthur Home (41)

### AUBURN

Parks Memorial Home (54)

### AURORA

Borealis Nursing Home (112)

St. Charles Hospital (25)

### AVON

Avon Nursing Home, Inc. (48)

### BELLEVILLE

Memorial Nursing Home (111)

### BENTON

Franklin Hospital Skilled Nursing (81)

### BERWYN

Fairfax Ger. & Conv. Center (106)

R N Convalescent Home (20)

### BLOOMINGTON

Heritage Manor (86)



**CARBONDALE**

Styrest Nursing Home (54)

**CARLINVILLE**

Lake View Nursing Home (74)

**CASEY**

Casey Nursing Home (92)

**CENTRALIA**

Centralia Fireside House, Inc. (46)

**CHARLESTON**

Hilltop Nursing Home, Inc. (37)

**CHESTER**

St. Ann's Home (45)

**CHICAGO**

All American Nursing Home (144)

Alshore House (53)

Augustana Home for Aged (28)

Austin Congress Nursing Home (136)

Bethany Methodist Hosp. (87)

Bryn Mawr House, Inc. (183)

Carmen Manor (114)

Dearborn House, Inc. (128)

Drexel Home (132)

Elston Home, Inc. (112)

Fargo Beach Home (143)

Fountainebleau Manor, Inc. (30)

Fox River Rehab. Center (74)

Garden View Home (57)

Jewish Home for Aged (232)

Johnson Rehab. Nursing Home (76)

Kostner Manor (117)

Melbourne Convalescent Home (170)

Montgomery Convalescent Home (80)

Northwest Home for Aged (26)

Park House (85)

Park View Home (31)

Rosewood Manor, Inc.

South Shore Kosher Rest Home, Inc. (90)

South Shore Pavilion (113)

Sovereign Home (29)

Vincennes Manor (110)

Wellington Plaza (91)

Wrightwood Nursing Home (90)

**CHILLICOTHE**

ParkHill Extended Care Facility (66)

**COAL VALLEY**

Oak Glen Nursing Home (286)

**COLCHESTER**

Colchester Nursing Home (49)

**DECATUR**

Americana Nursing Center of Decatur (65)

Lakeshore Manor (28)

**DEKALB**

DeKalb Public Hospital (15)

Pine Acres Retirement Center (60)

**DES PLAINES**

Brookwood Convalescent Center, Inc. (111)

Golf Road Pavilion (142)

**DIXON**

Orchard Glen, Inc. (54)

**DU QUOIN**

Fair Acres Nursing Home (74)

**ELGIN**

Simpson House, Ltd. (67)

**ELMHURST**

Elmhurst Extended Care Center, Inc. (42)

**EVANSTON**

Dobson Plaza, Inc. (52)

Presbyterian Home (75)

Three Oaks Nursing Center (124)

**EVERGREEN**

Evergreen Gardens, Inc. (40)

Peace Memorial Home (60)

**FULTON**

Harbor Crest Home (49)

**GALESBURG**

Americana Nursing Center of Galesburg (67)

**GLENVIEW**

Golf Mill Nursing Home, Inc. (166)

**GODFREY**

Blu-Fountain Manor (75)

**GODFREY**

Blu-Fountain Manor Nursing Home (29)

**GOLDEN**

Good Shepard Home, Inc. (48)

**HARVEY**

Heather Manor Convalescent Center (49)

**HIGHLAND PARK**

Villa St. Cyril (39)

**HIGHWOOD**

Pavilion of Highland Park (59)

**HILLSIDE**

Oakridge Convalescent Home (16)

**HOPEDALE**

Hopedale Nursing Home (86)

**JACKSONVILLE**

Modern Care Conv. & Nsg. Home (40)

**JOLIET**

Americana Nursing Center of Joliet (92)

Our Lady of Angels Ret. Home (22)

Salem Home for Aged (26)

St. Patricks Residence (20)

**KANKAKEE**

Americana Nursing Center of Kankakee (92)

Riverside Hospital (50)

**LACON**

St. Joseph Nursing Home (54)

**LAGRANGE**

LaGrange Colonial Manor Convalescent & Nursing Center (49)

**LAWRENCEVILLE**

Methodist Home (40)

**LEWISTOWN**

Clarytona Manor, Inc. (49)

**LIBERTYVILLE**

Lake County Nursing Home (153)

**LINCOLN**

Abraham Lincoln Mem. Extended Care (58)

Christian Nursing Home (48)

Mary Henry Nursing Home (52)

**LITCHFIELD**

Litchfield Nursing Home (48)

**LOVES PARK**

Fountain Terrace (49)

**MACOMB**  
 Americana Nursing Center of Macomb (56)

**MARSHALL**  
 Burnside Nursing Home, Inc. (87)

**MATTOON**  
 Douglas Nursing Center (49)

**MENDOTA**  
 Sunrise Nursing Home (49)

**MOLINE**  
 Americana Nursing Center of Moline (67)

**MORTON**  
 Restmor, Inc. (78)

**MT. MORRIS**  
 Pinecrest Manor (50)

**MT. VERNON**  
 Good Samaritan Hosp. (20)  
 Hickory Grove Manor (100)

**MT. ZION**  
 Woodland Inc. Nursing Home (70)

**MUNDELEIN**  
 North Riverwood Center, Inc. (65)

**NAPERVILLE**  
 Americana Nursing Center (95)

**NEWTON**  
 Newton Rest Haven (29)

**NILES**  
 Pleasantview Conv. Nursing Ctr., Inc. (91)

**NORMAL**  
 Americana Nursing Center of Bloomington-Normal (88)

**NORTHBROOK**  
 Edenvue Convalescent and Geriatric Center, Inc. (142)  
 Northbrook Nursing Home and Rehabilitation Center, Inc. (71)

**OAK LAWN**  
 Monticello Convalescent Ctr. (50)  
 Oak Lawn Convalescent and Geriatric Home (52)  
 Parkside Gardens Nursing Home (77)

**O'FALLON**  
 Parkview Colonial Manor (107)

**OLNEY**  
 Burgin Manor Nursing Home (26)

**OTTAWA**  
 Highland San. & Conv. Home of LaSalle County (61)  
 Pleasant View Luther Home (54)

**PALATINE**  
 Plum Grove Nursing Home, Inc. (46)

**PARK RIDGE**  
 St. Matthew Lutheran Home (29)

**PEKIN**  
 Pekin Mem. Hosp. (39)

**PEORIA**  
 Americana Nursing Center of Peoria (65)  
 High View Nursing Home (68)

**PEORIA HEIGHTS**  
 Fireside House, Inc. (108)

**PERU**  
 Heritage Manor (55)

**PETERSBURG**  
 Menard Convalescent Center, Inc. (54)

**PITTSFIELD**  
 Pittsfield Nursing Home (74)

**PONTIAC**  
 Evenglow Lodge (42)

**QUINCY**  
 Methodist Sunset Home (64)  
 Lincoln-Terrace Nursing Home, Inc. (84)

**ROBBINS**  
 Esma A. Wright Convalescent Center (50)

**ROCHELLE**  
 Americana Nursing Center of Rochelle (49)

**ROCK FALLS**  
 Colonial Acres Rest Home (55)

**ROCKFORD**  
 Alma Nelson Manor (36)  
 Americana Nursing Center of Rockford (114)  
 Riverside Manor (59)  
 Wesley Willows (30)

**ROSICLARE**  
 Hardin County General Hosp. (4)

**SALEM**  
 Twin Willows Nursing Center (28)

**SHELBYVILLE**  
 Shelby County Mem. Hospital (20)  
 Young's Shelbyville Restorium (22)

**SKOKIE**  
 Old Orchard Manor (61)  
 Village Nursing Home (84)

**S. CHICAGO HEIGHTS**  
 Suburgan Con. Nursing Home (49)

**SPRINGFIELD**  
 Americana Nursing Center (72)  
 Everett McKinley Dirksen Home (109)  
 Rutledge Manor Care Home, Inc. (31)

**STERLING**  
 Colonial Acres Rest Home (70)

**STREATOR**  
 Heritage Manor (27)

**SULLIVAN**  
 East View Manor (52)

**SUMNER**  
 Red Hills Rest Haven Nursing Home (44)

**SWANSEA**  
 Castle Haven Nursing Home (51)

**TAYLORVILLE**  
 Meadow Manor (36)

**TECHNY**  
 St. Ann's Home & Infirmary (47)

**TUSCOLA**  
 Douglas County Jarman Memorial Hospital (6)

**URBANA**  
 American Nursing Center (50)  
 Fontana Nursing Care Center (47)

**WATSEKA**  
 Iroquois Resident Home (58)

**WASHINGTON**  
 Washington Nursing Center (88)

**WATERLOO**  
 Monroe County Nursing Home (60)

**WAUKEGAN**

Terrace Nursing Home (43)  
Waukegan Pavilion Nursing Home (96)

**WINFIELD**

Abbey-Winfield Convalescent Home (49)

**WHEATON**

DuPage County Convalescent Home (53)

**INDEPENDENT LABORATORIES**

The Independent Laboratories listed below have been surveyed by the Illinois Department of Public Health and certified by the U.S. Department of Health, Education and Welfare as providers of service for Medicare beneficiaries as of July 24, 1969. The specific tests reimbursable by Medicare are indicated in parenthesis following the name of each laboratory:

- A. Microbiology**
- B. Serology**
- C. Clinical Chemistry**
- D. Hematology**
- E. Immunohematology**
- F. Tissue Pathology**
- G. Exfoliative Cytology**

**ARGO**

Argo Clinical Lab. (BCD)  
6252 Archer Road 60501

**ARLINGTON HEIGHTS**

Arlington Medical Lab. (ABCDEFGF)  
1430 N. Arlington Heights Rd., 60004  
Village Medical Lab. (CDE)  
1009 S. Evergreen 60005

**AURORA**

Clinical Lab. (ABCDEFGF)  
143 S. Lincoln 60505

**BARRINGTON**

Barrington Medical Lab. (ABCD)  
606 S. Northwest Hwy. 60010

**BELLEVILLE**

St. Clair Medical Lab. (ABCDGF)  
301 W. Lincoln 62220

**BERWYN**

Kenilworth Lab. (ABCDE)  
6905 W. Cermak Rd., 60402

**BLOOMINGTON**

Bloomington Cornbelt Biocheml. Lab. (ABCD)  
705 North East 61701  
Hans H. Stroink, M.D. (ABCDEFGF)  
214 Unity Bldg. 61701

**BROADVIEW**

Broadview Physicians Lab. (ABCDE)  
220 W. Roosevelt 60155

**CHAMPAIGN**

Doctors Bldg. Lab., (BCDE)  
301 E. Springfield 61820

**CHICAGO**

A & D Medical Lab. (ABCDE)  
3848 W. 63rd St. 60629  
A & M Clinical Lab.  
2320 W. Peterson 60645  
A. S. Cahan, M.D. (BCDE)  
4010 W. Madison St. 60624  
Accurate Medical Lab (ABCDE)  
5959 N. Washtenaw 60645  
Acorn Laboratories (G)  
2658 W. 95 St. 60642  
Almar Clinical Lab. (ABCDE)  
2457 W. Peterson Ave. 60645

Anatomic & Clinical Pathology Lab. (G)  
P.O. Box 919 60642

Anderson Clinical Lab. (BCDE)  
811 W. Wellington 60657

Apogee Medical Labs. Inc. (ACD)  
5962 Lincoln Ave. 60645

Aquinas Medical Lab. (C)  
11102 S. Artesian Ave., 60655

Arcade Clinical Lab. (ACDE)  
6355 Broadway 60626

Associated Medical Lab., Inc. (ABCDE)  
4753 Broadway 60640

Auburn Clinical Lab. (BCD)  
946 W. 79th St. 60620

Austin Clinical Lab. (BCDE)  
5679 W. Madison St. 60644

Avenue Medical Lab. (ABCD)  
11318 S. Michigan Ave. 60628

Bel-Aire Medical Bldg. Lab. (ACDEG)  
8501 Cottage Grove 60619

Beverly-Sheridan Labs., Inc., (ABCD)  
9449½ S. Ashland 60620

Brooks Clinical Lab. (ABCDE)  
4006 Milwaukee Ave. 60641

Central Doctors' Medical Lab., Inc. (CD)  
2715 N. Central 60639

Central X-Ray & Clinical Lab. (ABCDEFGF)  
111 N. Wabash 60602

Chathan-Avalon Clinical Lab. (BCDE)  
8222 Martin Luther King Dr. 60619

Chemical Consulting Corp. (C)  
6018 W. Fullerton 60639

Clearing Clinic, Inc. (ABCDE)  
5548 W. 65th St. 60638

Colonial Medical Lab. (ABCD)  
2024 W. 79th St. 60620

Community Medical Lab. (ABCDE)  
3613 Roosevelt Rd. 60624

Doctors Medical Lab., Inc. (ABD)  
11450 S. Michigan Ave. 60628

Drexal Home (CD)  
6140 S. Drexel 60637

Drs. Mason & Baron (ABCDEFGF)  
2056 N. Clark St. 60614

Foster-Western Clinical Lab. (ABCDE)  
5214 N. Western Ave. 60625



Gerber X-Ray & Clinical Lab. (ABCDE)  
 2400 W. Devon 60645  
 Gerson Clinical Lab. (ACD)  
 1 N. Pulaski Rd. 60624  
 Highland Medical Labs. (ABCDE)  
 7922 S. Ashland Ave. 60620  
 Humboldt Clinical Lab. (D)  
 2018 S. Ashland 60608  
 Hyde Park Medical Lab. (BCDG)  
 5240 S. Harper, 60615  
 K & K Clinical Lab., Inc. (ABCD)  
 5935 W. Addison 60634  
 Kendon Medical Lab., Inc. (ABCD)  
 8625 S. Cicero, 60652  
 Letho Clinical Labs. (ABCDEFG)  
 1325 S. Racine, 60608  
 Marquette Medical Lab. (ABCDE)  
 6132 S. Kedzie 60629  
 Mart X-Ray Lab., Co. (ACD)  
 7-110 Merchandise Mart 60654  
 Maryhaven Medical Lab., Inc. (CD)  
 8700 S. Dante 60619  
 Medic Clinical Lab. (B)  
 6317 S. Western Ave. 60636  
 Medical Associates of Chicago (ABCDEFG)  
 3233 Martin Luther King Dr. 60616  
 Medical Center Clinical Labs. (CD)  
 3528 N. Ashland 60657  
 Metro Lab. (ABCDEFG)  
 1737 W. Howard 60626  
 Metro Lab. (ABCDEFG)  
 30 N. Michigan Ave. 60602  
 Metro Lab. (ABCDEFG)  
 2376 E. 71st St. 60649  
 Michael Reese Research Foundation (BDE)  
 530 E. 31st St. 60616  
 Midwest Cytology Lab. (G)  
 5707 N. Ashland Ave. 60626  
 Molay Medical Labs. (ABCD)  
 185 N. Wabash 60601  
 Murphy—Uptown Clinical Lab (CD)  
 4763 Broadway 60640  
 North-Kimball Medical Labs. (BCDE)  
 1579 N. Milwaukee 60622  
 Ogden Hill Medical Lab. (B)  
 3451 W. 63rd St. 60629  
 Omens Medical Bldg. Lab. (B)  
 5720 W. North Ave. 60639  
 P. M. D. Clinical Lab. (CD)  
 2017 W. 95th St. 60643  
 Park Grove Medical Lab. (ABCDE)  
 8048 S. Cottage Grove 60619  
 Parkview Home (ABCD)  
 1401 N. California 60622  
 Parkway Labs. (ABCDE)  
 408 E. Marquette Rd. 60637  
 Pathology Associates (ABCDEFG)  
 55 E. Washington 60602  
 Peterson-Western X-Ray Lab. (ABCDE)  
 2424 W. Peterson Ave. 60645  
 Physicians & Surgeons Clinical Lab (ABCDE)  
 6710 W. North Ave. 60635  
 S & S Medical Lab. (CD)  
 532 E. 47th St. 60653  
 Sarian Medical Labs. (ABCDE)  
 6257 S. Archer, 60638  
 Sauganash Medical & X-Ray Lab. (ABCD)  
 4833 W. Peterson 60646  
 South Central Medical Lab. (ABCDE)  
 5050 S. State St. 60609  
 South East Medical Lab. (CD)  
 1832 E. 87th St. 60617  
 Thornburg Clinical Lab. (ABCDE)  
 720 N. Michigan 60611  
 Thornburg Clinical Lab (BC)  
 841 E. 63rd St. 60637  
 United Medical Lab., Inc. (ABCDEFG)  
 8 S. Michigan 60603  
 University Lab. (ABCDE)  
 5 S. Wabash 60603  
 West Lawn Medical Lab. (ABCD)  
 4255 W. 63rd St. 60629  
 Westerly Medical Lab. (ABCDE)  
 10404 S. Western, 60643  
 Westridge Clinical Lab. (ABCDE)  
 6450 N. California 60645  
 Westside Clinical Lab. (CD)  
 3808 W. Roosevelt Rd., 60624  
 Zeitlin X-Ray & Clinical Lab. (ABCDE)  
 2800 N. Milwaukee 60618  
 200 Clinical Lab. (BCDE)  
 200 E. 75th St. 60619  
 2011 Clinical Lab. (ABCD)  
 2011 E. 75th St. 60649  
 63rd Medical Lab. (ABCDE)  
 749 W. 63rd St. 60621  
 9450 Francisco Med. Lab. (CDE)  
 9450 S. Francisco Ave. 60642  
 95th St. X-Ray & Clinical Lab. (ABCDE)  
 243 W. 95th St. 60628  
**CICERO**  
 Suburban Labs., Inc. (ABCD)  
 2137 S. Lombard 60650  
**DECATUR**  
 Central Clinical Lab. (ABCDE)  
 1314 N. Main 62526  
**DEERFIELD**  
 Colrad Clinical Labs. (ABCD)  
 747 Deerfield Rd. 60015  
**DEKALB**  
 De Graffenried & Fisher Clinical Lab.  
 (ABCDEFG)  
 1838 Sycamore Rd. 60115  
**DES PLAINES**  
 De Ridge Clinical Lab. (ABCDE)  
 3200 Dempster 60016  
**DIXON**  
 Physicians Medical Lab. (ABCD)  
 101 First St. 61021  
**EAST ST. LOUIS**  
 Appleton Lab. (BCD)  
 234 Collinsville Ave. 62201  
 Clinical Lab. (ABCDE)  
 4601 State St. 62201

**ELGIN**

Fox Valley Medical Lab. (ABCDEFGF)  
860 E. Summit 60120

**ELMHURST**

Haven Clinical Lab. (ABCD)  
103 Haven Rd. 60126  
Sandahl Medical Labs. (ABCDE)  
135 S. Kenilworth 60126

**EVANSTON**

COS Building Lab. (ABCDEFGF)  
2500 Ridge Ave. 60201  
Gyne Cytology Lab., Inc (G)  
636 Church St. 60201  
Pathology Associates (ABCDEFGF)  
636 Church St. 60201

**EVERGREEN PARK**

Anatomic & Clinical Pathology Lab. (G)  
P.O. Box 919 60642  
North Beverly Clinical Lab. (BCDE)  
3759 W. 95th St. 60642

**FOREST PARK**

Bowers Lab. (ABCDE)  
7318 Madison St. 60130

**FRANKLIN PARK**

Franklin Park Medical Lab. (CDEFG)  
9711 Grand 60131

**GALESBURG**

Galesburg Clinic Lab. (ABCDE)  
320 N. Kellogg 61401

**GLENVIEW**

NW Sub X-Ray & Clinical Lab. (ABCDE)  
924 Waukegan, 60025

**HARVEY**

Graham Clinical Lab. (BC)  
468 E. 147th St. 60426

**HIGHLAND PARK**

Highland Park Medical Lab. (ABCDE)  
1950 Sheridan Rd. 60035

**HINSDALE**

Pathology Associates (ABCDEFGF)  
40 S. Clay 60521

**HOFFMAN ESTATES**

Twinbrook Medical Lab., Inc. (ABD)  
Golf & Roselle Rds. 60172

**JOLIET**

Associated Pathologists (G)  
2112 W. Jefferson St. 60435  
Central Lab. (ABCDE)  
57 W. Jefferson St. 60431  
Osler Labs., Inc. (CD)  
120 N. Scott St. 60431  
Prescription Shop Lab., (ABCE)  
56 N. Chicago 60431  
Woodruff Lab., Inc. (ABCD)  
250 N. Ottawa St. 60431

**KANKAKEE**

Medical Center Lab. (ABCDE)  
1309 E. Court 60901

**LA GRANGE**

La Grange Medical Building Lab. (BCDE)  
47 S. Sixth Ave. 60525

**LANSING**

De Graff Clinical Lab. (ABCDE)  
3341 Ridge Rd. 60438

**LA SALLE**

Medical Lab. (ABCDE)  
555 2nd St. 61301

**MAYWOOD**

Joslyn Clinic Lab. (ABCDE)  
1908 St. Charles Rd. 60153

**McHENRY**

McHenry Medical Group (ABCDEFGF)  
1110 N. Green St. 60050

**MOLINE**

Martin Clinical Lab. (ABCDEFGF)  
1520 7th St. 61265

**MORTON GROVE**

Sommerfeld Med. Lab. (ABCD)  
5818 Dempster St. 60003

**MOUNT PROSPECT**

Mt. Prospect Clinical Lab. (ACDE)  
321 W. Prospect 60056  
Prospect Clinical Lab. (ABCD)  
1060 W. Northwest Hwy. 60056

**NORTHBROOK**

Northbrook Cl. & X-Ray Labs. (ABCD)  
1775 Walters 60062

**OAK BROOK**

Pathology Associates (ABCDEFGF)  
120 Oak Brook Ctr. MI. 60521

**OAK PARK**

American Medical Lab. (BCD)  
6441 W. North Ave. 60302  
Arms Medical Lab. (CD)  
414 S. Oak Park Ave. 60302  
Hill Clinical Lab. (ABCDEFGF)  
1011 Lake St. 60301  
James B. Hartney, M.D. (FG)  
410 Lake St. 60302  
Mac Gregor Lab. (BCDE)  
6144 W. Roosevelt Rd. 60304

**OGLESBY**

Physicians Clinical Lab. (CD)  
338 E. Walnut St. 61348

**PALOS HEIGHTS**

Palos Medical Lab. (ABCDE)  
12150 S. Harlem 60463

**PEKIN**

The Medical Lab. (ABCDE)  
519 Margaret 61554

**PEORIA**

M B Clinical Lab. (ABCDE)  
818 Main Street 61606  
Medical Center Labs. (ABCDEFGF)  
416 St. Marks Ct. 61603  
Wm. Schwarzendruber Lab. (ABCDE)  
300 E. War Mem. Dr. 61614

**ROCKFORD**

Medical Labs. of Pathology (ABCDEFGF)  
1221 E. State St. 61108

**SKOKIE**

Dempster Street Pathology Lab. (BDFG)  
4240 Dempster 60076  
Lincoln Medical Lab. (CD)  
4535 Oakton 60076  
North Sub. Clinical Lab. (ABCDE)  
4801 Church St. 60076  
Pasco Medical Lab. (BCDG)  
64 Old Orchard 60076

**SPRINGFIELD**

Capitol Clinical Labs. (ABCDE)  
1104 S. Second 62704  
Physicians Medical Lab. (ABCDE)  
501 N. 6th St. 62705  
Springfield Clinical Lab. (ABCD)  
1025 S. 7th St. 62703

**VILLA PARK**

Ardmore Pharmacy Inc. (BCD)  
317 S. Ardmore Ave. 60181

**WAUKEGAN**

Besley-Waukegan Clinic (ABCDE)  
215 N. Sheridan Rd. 60085  
Physicians & Surgeons Lab. (ABCDEFG)  
1616 W. Grand 60085

**WHEATON**

Drs. Mason & Barron (ABCDEFG)  
200 E. Willow 60187

**WILMETTE**

Wilmette Clinical Lab. (ABCDEFG)  
165 Green Bay Rd. 60091

**WINNETKA**

Clini-Tech Labs., Inc. (ABCD)  
1048 Gage St. 60093  
Winnetka Clinical Lab. (ABCDE)  
725 Elm St. 60093

**ZION**

Zion Clinic Lab (CDE)  
2629 Sheridan Rd. 60099

**APPROVED LABORATORIES-PKU-FLUOROMETRIC TEST**

These laboratories are approved for the use of this procedure for both screening and quantitative determinations.

**ALTON**

Alton Memorial Hospital Laboratory

**AURORA**

Clinical Laboratory-Aurora Medical Park

**BENTON**

Franklin Hospital Laboratory

**BERWYN**

Kenilworth Laboratories

**CHAMPAIGN**

Burnham City Hospital Laboratory

**CHICAGO**

Chicago Wesley Memorial Hospital Laboratory  
Columbus Hospital Laboratory  
Edgewater Hospital Laboratory  
Illinois Research & Education Hospital Laboratory  
Mercy Hospital Laboratory  
Michael Reese Hospital Laboratory  
Mt. Sinai Hospital Laboratory  
Presbyterian-St. Luke's Hospital Lab.  
St. Joseph's Hospital Laboratory  
Walther Memorial Hospital Laboratory  
Weiss Memorial Hospital Laboratory

**DANVILLE**

Lake View Memorial Hospital Clinical Laboratory  
St. Elizabeth's Hospital Laboratory

**DECATUR**

Decatur & Macon County Hospital Laboratories  
St. Mary's Hospital Laboratory

**ELGIN**

Sherman Hospital Laboratory

**EVANSTON**

Evanston Hospital Laboratory

**NAPERVILLE**

Edward Hospital Laboratory

**OAK LAWN**

Christ Community Hospital Laboratory

**OAK PARK**

West Suburban Hospital Laboratory

**PEORIA**

Methodist Hospital Laboratory  
St. Francis Hospital Clinical Laboratories

**ROCKFORD**

Rockford Memorial Hospital Laboratory  
Swedish-American Hospital Laboratory

**SKOKIE**

Skokie Valley Community Hospital Lab.

**URBANA**

Carle Hospital Clinic Laboratory  
Mercy Hospital Clinical Laboratory

**WAUKEGAN**

St. Therese's Hospital Laboratory

**BURLINGTON, IOWA**

F. D. Winter, M.D.

**EVANSVILLE, INDIANA**

Mid-America Pathology Service, Inc.

**KENOSHA, WISCONSIN**

Kenosha Memorial Hospital Laboratory



## APPROVED CHRONIC RENAL DIALYSIS CENTERS AND DIRECTORS

Michael Reese Hospital and Medical Center  
29th Street and Ellis Avenue  
Chicago, Illinois 60616  
Dr. Alan Kanter  
Presbyterian-St. Luke's Hospital  
1753 West Congress Parkway  
Chicago, Illinois 60612  
Dr. Franklin D. Schwartz  
Washington University School of Medicine  
(Barnes Hospital)  
660 South Euclid Avenue  
St. Louis, Missouri 63110  
Dr. Neal S. Bricker  
Memorial Hospital  
Renal Unit  
First and Miller Streets  
Springfield, Illinois 62701  
Dr. Alton Morris  
St. Francis Hospital  
523 Northeast Glen Oak  
Peoria, Illinois 61603  
Dr. James D. Myers

University of Illinois Research  
and Educational Hospitals  
840 South Wood Street  
Chicago, Illinois 60612  
Dr. Clarence L. Gantt  
Passavant Memorial Hospital  
303 East Superior Street  
Chicago, Illinois 60611  
Dr. Francesco del Greco  
Mount Sinai Hospital Medical Center  
Renal Unit  
Fifteenth and California Avenues  
Chicago, Illinois 60608  
Dr. George Dunea  
University of Chicago Hospitals and Clinics  
950 East 59th Street  
Chicago, Illinois 60637  
Dr. Frank P. Stuart  
West Suburban Hospital  
518 North Austin Boulevard  
Oak Park, Illinois 60302  
Dr. Robert C. Muehrcke

## APPROVED CHRONIC RENAL DIALYSIS UNITS AND DIRECTORS

The Children's Memorial Hospital  
2300 Children's Plaza  
Chicago, Illinois 60614  
Dr. Gilbert Given  
Rockford Memorial Hospital  
2300 North Rockton Avenue  
Rockford, Illinois  
Ewald T. Sorensen, M.D.  
Evanston Hospital  
2650 Ridge Avenue  
Evanston, Illinois 60201  
Dr. Bernard Adelson

LaRabida Jackson Park Sanatorium  
Jackson Park & East 65th Street  
Chicago, Illinois  
Berton Grossman, M.D.

For Further Information Contact:

Wm. J. Cassel, Jr., M.D., M.P.H.  
Chief, Bureau of Chronic Illness  
Illinois Department of Public Health  
Room 518, State Office Building  
Springfield, Illinois 62706  
Phone: (217) 525-2576

## ARTIFICIAL KIDNEY CENTERS

**As of Aug. 7, 1969, these centers may be contacted regarding renal dialysis.**

Children's Memorial Hospital  
2300 Children's Plaza  
Chicago

Phone: 348-4040  
Person in Charge: Alan Siegel, M.D.  
Location in Hosp: Nephrology

Edgewater Hospital  
5700 N. Ashland Avenue  
Chicago

Phone: UP 8-6000  
Person in Charge: Rogelio Riera, M.D.  
Location in Hosp: Surgery

Michael Reese Hospital  
2929 South Ellis Avenue  
Chicago

Phone: 225-5525  
Person in Charge: Dr. Allan Kanter  
Location in Hosp: Department of Medicine  
Division of Renal Medicine

Mt. Sinai Hospital  
California Ave. at 15th Street  
Chicago

Phone: 277-4000  
Person in Charge: Dr. Philip Friedman  
Location in Hosp: Department of Medicine

## ARTIFICIAL KIDNEY CENTERS (Continued)

Passavant Memorial Hospital 303 E. Superior Street Chicago	Phone: WH 4-4200 Person in Charge: Francesco del Greco, M.D. Location in Hosp: Artificial Kidney
Presbyterian-St. Lukes Hospital 1753 West Congress Parkway Chicago	Phone: 738-4411 Person in Charge: Robert M. Kark, M.D. Location in Hosp: Division of Medicine
University of Chicago Hospital 950 E. 59th Street Chicago	Phone: MU 4-6100 Person in Charge: Dr. Marvin Forland Location in Hosp: Department of Medicine
University of Illinois Research and Educational Hospital 840 South Wood Street Chicago	Phone: 663-7591 Person in Charge: Clarence Gantt, M.D. Location in Hosp: Clinical Research Center
St. Joseph Hospital 277 Jefferson Avenue Elgin	Phone: 741-5400 Person in Charge: Charles K. Bobelis, M.D. Location in Hosp: Artificial Kidney Dept.
Evanston Hospital 2650 Ridge Avenue Evanston	Phone: 492-2000 Person in Charge: Dr. Bernard Adelson Location in Hosp: Kidney Dialysis Dept.
Riverside Hospital 350 N. Wall Kankakee (acute cases only)	Phone: 933-1671 Person in Charge: Dr. Eugene Anderson Location in Hosp: Intensive Care
West Suburban Hospital 518 North Austin Boulevard Oak Park	Phone: EU 3-6200 Person in Charge: Robert Muehrcke, M.D. Location in Hosp: Kidney Dialysis Room-2nd Fl.
St. Francis Hospital 530 N.E. Glen Oak Peoria	Phone: 674-7731 Ext. 605 Person in Charge: Dr. J. D. Myers Location in Hosp: Chronic Dialysis Unit
Swedish-American Hospital 1316 Charles Street Rockford	Phone: 968-6898 Person in Charge: Dr. John Berry Location in Hosp: Intensive Care
Memorial Hospital First & Miller Streets Springfield	Phone: 528-2041 Person in Charge: Antonio Versaci, M.D. Location in Hosp: Intensive Care
St. John's Hospital 701 E. Mason Street Springfield	Phone: 544-4451 Person in charge: Sister M. Jane
Barnes Hospital Barnes Hospital Plaza St. Louis, Missouri	Phone: 367-6400 Person in Charge: Neal Bricker, M.D. Location in Hosp: Second Floor
St. Francis Hospital 825 Good Hope Street Cape Girardeau, Missouri	Phone: 334-4461 Person in Charge: Sister M. Venard Location in Hosp: Surgery

Note: All listed centers have also been approved for chronic hemodialysis except the following:  
 Edgewater Hospital, Chicago  
 St. Joseph Hospital, Elgin  
 Riverside Hospital, Kankakee  
 Swedish-American Hospital, Rockford  
 St. John's Hospital, Springfield  
 St. Francis Hospital, Cape Girardeau, Mo.

## POISON CONTROL CENTERS IN ILLINOIS

### AURORA

Copley Memorial Hospital  
Lincoln & Weston Avenues  
896-4611, Ext. 725  
St. Charles Hospital  
400 E. New York Street  
897-8714, Ext. 50

### BELLEVILLE

Memorial Hospital  
4501 North Park Dr.  
233-7750, Ext. 286

### BELVIDERE

Highland Hospital  
1625 S. State St.  
547-5441

### BERWYN

MacNeal Memorial Hospital  
3249 S. Oak Park Ave.  
484-2211 Ext. 311 and 312

### BLOOMINGTON

Mennonite Hospital  
807 North Main St.  
828-5241, Ext. 311  
St. Joseph's Hospital  
2200 E. Washington St.  
829-9481, Ext. 354

### CAIRO

St. Mary's Hospital  
2020 Cedar St.  
734-2400, Ext. 45

### CANTON

Graham Hospital Association  
210 W. Walnut St.  
647-5240, Ext. 48

### CARBONDALE

Doctors Hospital  
404 W. Main St.  
457-4101, Ext. 23

### CENTRALIA

St. Mary's Hospital  
400 N. Pleasant Ave.  
532-6731, Ext. 626

### CHAMPAIGN

Burnham City Hospital  
311 E. Stoughton St.  
337-2533

### CHANUTE AIR FORCE BASE\*

United States Air Force Hospital  
893-3111, Ext. 6234 and 6233

### CHESTER

Memorial Hospital  
1900 State St.  
826-2367, Ext. 44

### CHICAGO

Children's Memorial Hospital  
2300 Children's Plaza  
348-4040, Ext. 338  
Cook County Hospital  
1825 West Harrison St.  
633-6542; 633-6544  
University of Illinois Hospitals  
840 South Wood St.  
663-7297  
Mercy Hospital  
2510 Martin Luther King Dr.  
842-4700  
Michael Reese Hospital  
29th Street & Ellis Ave.  
225-5525, Ext. 761  
Night Ext. 261  
Mt. Sinai Hospital  
15th & California  
277-4000, Ext. 297-298  
Municipal Contagious Disease San.  
3026 South California Ave.  
247-5700  
Presbyterian-St. Lukes Hospital  
(Master Chicago Center For Information,  
Treatment & Reference on Poisoning)  
1753 W. Congress Parkway  
738-4411, Ext. 2267  
Resurrection Hospital  
7435 West Talcott Ave.  
774-8000, Ext. 235-236  
Wyler Silvain and Arma Children's Hospital  
950 E. 59th St.  
684-6100 Ext. 6231  
Night Ext. 5412

### DANVILLE

Lake View Memorial Hospital  
812 N. Logan Ave.  
443-5221  
St. Elizabeth's Hospital  
600 Sager St.  
442-6300

### DECATUR

Decatur Memorial Hospital  
2300 N. Edward St.  
877-8121, Ext. 675-676  
St. Mary's Hospital  
1800 E. Lake Shore Dr.  
429-2966, Ext. 640

### DES PLAINES

Holy Family Hospital  
100 North River Road  
299-2281, Ext. 856

\*Limited for treatment of military personnel and families, except for indicated emergencies.



**EAST ST. LOUIS**

Christian Welfare Hospital  
1509 Illinois Ave.  
874-7076, Ext. 231  
St. Mary's Hospital  
129 North 8th St.  
274-1900

**EFFINGHAM**

St. Anthony's Hospital  
503 North Maple St.  
342-2121, Ext. 67

**ELGIN**

St. Joseph's Hospital  
277 Jefferson Ave.  
741-5400, Ext. 69  
Sherman Hospital  
934 Center St.  
742-9800, Ext. 681, 682, 683

**ELMHURST**

Memorial Hospital of DuPage County  
315 Schiller St.  
833-1400

**EVANSTON**

Community Hospital  
2040 Brown Ave.  
869-5044, Ext. 54  
Night Ext. 58  
Evanston Hospital  
2650 Ridge Ave.  
492-6460  
St. Francis Hospital  
355 Ridge Ave.  
492-2440

**EVERGREEN PARK**

Little Company of Mary Hospital  
2800 W. 95th St.  
422-6200, Ext. 1211

**FAIRBURY**

Fairbury Hospital  
519 South Fifth St.  
692-2346

**FREEPORT**

Freeport Memorial Hospital  
420 South Harlem Ave.  
233-4131, Ext. 228

**GALENA**

Northwestern Illinois Community Hospital  
Summit Street  
777-1340

**GALESBURG**

Galesburg Cottage Hospital  
674 North Seminary St.  
343-4121, Ext. 356  
St. Mary's Hospital  
239 South Cherry St.  
343-3161, Ext. 203

**GRANITE CITY**

St. Elizabeth's Hospital  
2100 Madison Ave.  
876-2020, Ext. 224-257

**HARVEY**

Ingalls Memorial Hospital  
15510 Page Ave.  
333-2300

**HIGHLAND**

St. Joseph's Hospital  
1515 Main St.  
654-2171

**HIGHLAND PARK**

Highland Park Hospital Foundation  
718 Glenview Ave.  
432-8000, Ext. 561-562

**HINSDALE**

Hinsdale San. & Hospital  
120 North Oak St.  
323-2100, Ext. 336, 337, 338

**HOOPESTON**

Hoopeston Community Memorial Hospital  
701 E. Orange  
283-5531

**JACKSONVILLE**

Passavant Memorial Area Hospital  
1600 West Walnut  
245-9541

**JOLIET**

St. Joseph's Hospital  
333 N. Madison St.  
725-7133, Ext. 679, 793  
Silver Cross Hospital  
600 Walnut St.  
727-1711, Ext. 731

**KANKAKEE**

Riverside Hospital  
350 N. Wall St.  
933-1671  
St. Mary's Hospital  
150 South Fifth St.  
939-4111, Ext. 735

**KEWANEE**

Kewanee Public Hospital  
719 Elliott St.  
853-3361, Ext. 219

**LAKE FOREST**

Lake Forest Hospital  
660 North Westmoreland Road  
234-5600, Ext. 608

**LASALLE**

St. Mary's Hospital  
1015 O'Connor Ave.  
223-0607, Ext. 84, Night Ext. 46

**LIBERTYVILLE**

Condell Memorial Hospital  
Cleveland & Stewart Aves.  
362-2900, Ext. 325-326

**LINCOLN**

Abraham Lincoln Memorial Hospital  
315 Eighth St.  
732-2161, Ext. 365

**MACOMB**

McDonough District Hospital  
525 East Grant St.  
833-4101

**MATTOON**

Mem. Dist. Hosp. of Coles County  
2101 Champaign Ave.  
234-8881, Ext. 43,  
Night Ext. 29

**McHENRY**

McHenry Hospital  
3516 West Waukegan Road  
385-2200, Ext. 614

**MELROSE PARK**

Westlake Hospital  
1225 Superior St.  
681-3000, Ext. 239, 226

**MENDOTA**

Mendota Community Hospital  
Memorial Drive & Route 51  
2131, Ext. 22; Night Ext. 20

**MOLINE**

Moline Public Hospital  
635-10th Ave.  
762-3651, Ext. 232

**MONMOUTH**

Community Memorial Hospital  
1000 W. Harlem Ave.  
734-3141, Ext. 250

**MOUNT CARMEL**

Wabash General Hospital  
1418 College Drive  
262-4121

**MOUNT VERNON**

Good Samaritan Hospital  
605 North Twelfth St.  
242-4600, Ext. 303,  
Night Ext. 385

**NAPERVILLE**

Edward Hospital  
South Washington St.  
355-0450, Ext. 26

**NORMAL**

Brokaw Hospital  
Virginia at Franklin Ave.  
829-7685, Ext. 274

**OAK LAWN**

Christ Community Hospital  
4440 West 95th St.  
423-7000, Ext. 659, 600, 601

**OAK PARK**

West Suburban Hospital  
518 North Austin Blvd.  
383-6200, Ext. 605

**OLNEY**

Richland Memorial Hospital  
800 East Locust St.  
395-2131, Ext. 226

**OTTAWA**

Ryburn Memorial Hospital  
701 Clinton St.  
433-3100

**PARK RIDGE**

Lutheran General Hospital  
1775 Dempster St.  
692-2210

**PEKIN**

Pekin Memorial Hospital  
Corner of 14th & Court St.  
347-1151, Ext. 241 333

**PEORIA**

Methodist Hospital  
221 Northeast Glen Oak Ave.  
685-6511, Ext. 250, 360  
Proctor Community Hospital  
5409 North Knoxville Ave.  
691-4702, Ext. 791  
St. Francis Hospital  
530 Northeast Glen Oak Ave.  
674-2943

**PERU**

Peoples Hospital  
925 West Street  
223-3300

**PITTSFIELD**

Illini Community Hospital  
620 West Washington St.  
285-2113

**QUINCY**

Blessing Hospital  
1005 Broadway  
223-5811, Ext. 211  
St. Mary's Hospital  
1415 Vermont St.  
223-1200, Ext. 275

**ROCKFORD**

Rockford Memorial Hospital  
2400 North Rockton Ave.  
968-6861, Ext. 441  
St. Anthony's Hospital  
6666 E. State St.  
398-7600

Swedish-American Hospital  
1316 Charles St.  
968-6898, Ext. 602

**ROCK ISLAND**

St. Anthony's Hospital  
767-30th St.  
788-7631, Ext. 771

**ST. CHARLES**

Delnor Hospital  
975 North Fifth Ave.  
584-3300, Ext. 218

**SPRINGFIELD**

Memorial Hospital  
First and Miller Sts.  
528-2041, Ext. 333  
St. John's Hospital  
701 E. Mason St.  
544-6451, Ext. 375

**STREATOR**

St. Mary's Hospital  
111 E. Spring  
672-3189

**URBANA**

Carle Hospital  
611 W. Park St.  
337-3311  
Mercy Hospital  
1412 West Park Ave.  
337-2131

**WAUKEGAN**

St. Therese Hospital  
West Washington St.  
688-6470  
Night 688-6471  
Victory Memorial Hospital  
1324 North Sheridan Road  
688-4181

**WOODSTOCK**

Memorial Hospital for McHenry County  
527 West South St.  
338-2500, Ext. 32

**ZION**

Zion-Benton Hospital,  
2500 Emmaus Ave.  
872-4561, Ext. 240

**PACKAGED DISASTER HOSPITALS IN ILLINOIS**

**ALTON**

St. Joseph's Hospital

**ANNA**

Anna State Hospital

**AURORA**

Copley Memorial Hospital

**BELVIDERE**

St. Joseph's Hospital

**BENTON**

Franklin Hospital

**CAIRO**

St. Mary's Hospital

**CANTON**

Graham Hospital

**CARLINVILLE**

Carlville Hospital

**CENTRALIA**

St. Mary's Hospital

**CHARLESTON**

Community Memorial Hospital

**CHESTER**

Chester Memorial Hospital

**CHICAGO HEIGHTS**

St. James Hospital

**DANVILLE**

Lakeview Memorial  
St. Elizabeth's Hospital

**DECATUR**

Decatur Memorial Hospital

**DEKALB**

DeKalb Public Hospital

**DES PLAINES**

Forest Hospital  
Holy Family Hospital

**DIXON**

Dixon State School

**DU QUOIN**

Marshall Browning Hospital

**ELGIN**

Elgin State Hospital  
Sherman Hospital

**ELMHURST**

DuPage Memorial Hospital

**EVANSTON**

St. Francis Hospital

**FREEPORT**

Freeport Memorial

**GALESBURG**

Cottage Hospital  
Galesburg State Hospital



**HARRISBURG**

Harrisburg Hospital

**HIGHLAND PARK**

Highland Park Hospital

**HILLSBORO**

Hillsboro Hospital

**JACKSONVILLE**

Jacksonville State Hospital

**JERSEYVILLE**

Jersey Community Hospital

**JOLIET**

Silver Cross Hospital

**KANKAKEE**

Kankakee State Hospital

**LAKE FOREST**

Lake Forest Hospital

**LINCOLN**

Abraham Lincoln Memorial Hospital  
Lincoln State School

**LITCHFIELD**

St. Francis Hospital

**MANTENO**

Manteno State Hospital

**MATTOON**

Memorial Hospital of Coles County

**McHENRY**

McHenry Hospital

**METROPOLIS**

Massac Memorial Hospital

**MONMOUTH**

Monmouth Hospital

**MURPHYSBORO**

St. Joseph Memorial Hospital

**MORRIS**

Morris Hospital

**MOUNT CARMEL**

Wabash General

**NORMAL**

Brokaw Hospital

**OAK FOREST**

Oak Forest Hospital

**OAK LAWN**

Christ Community Hospital

**OLNEY**

Richland Memorial Hospital

**OTTAWA**

Ryburn Hospital

**PANA**

Pana Community Hospital

**PARIS**

Paris Hospital

**PEKIN**

Pekin Memorial Hospital

**PEORIA**

St. Francis Hospital

**PONTIAC**

St. James Hospital

**PRINCETON**

Perry Memorial Hospital

**QUINCY**

St. Mary's Hospital

**RED BUD**

St. Clement's Hospital

**ROCKFORD**

Swedish-American Hospital

**RUSHVILLE**

Sara D. Cubertson Hospital

**ST. CHARLES**

Delnor Hospital

**SANDWICH**

Sandwich Community Hospital

**STERLING**

Community General Hospital

**URBANA**

Carle Hospital

**WAUKEGAN**

St. Therese

**WATSEKA**

Iroquois Hospital

**WINFIELD**

Central DuPage Hospital

**WOOD RIVER**

Wood River Hospital

**ZION**

Zion-Benton Hospital

**HOME HEALTH AGENCIES**  
**CERTIFIED UNDER TITLE 18 (MEDICARE)**  
**JULY 24, 1969**

In addition to providing skilled nursing service, Home Health Agencies are certified for providing the following specific secondary services:

**M.S.S.—Medical Social Services**  
**Sp.T.—Speech Therapy**  
**P.T.—Physical Therapy**  
**O.T.—Occupational Therapy**  
**H.H.A.—Home Health Aide Service**  
**N.C.—Nursing Care**

**ALEDO**

Mercer County Health Department  
Court House, Aledo 61231  
P.T.—O.T.—Sp.T.—N.C.

**ALTON**

Family Service and Visiting Nurse Assn.  
211 E. Broadway, Alton 62002  
M.S.S.—N.C.—H.H.A.

**AURORA**

Visiting Nurse Association of Aurora  
320 N. Lake St. 60506  
Sp.T.—N.C.

**BELLWOOD**

Community Nursing Service of Proviso Township  
233 Mannheim Rd., Bellewood 60104  
P.T.—N.C.

**CAIRO**

Tri County Health Department  
1115 Cedar St., Cairo 62914  
Sp.T.—N.C.

**CAMBRIDGE**

Henry County Health Department  
Court House Annex, Cambridge 61238  
P.T.—N.C.

**CANTON**

Fulton County Health Department  
31 S. Main St., Canton 61520  
P.T.—N.C.

**CHAMPAIGN**

Champaign-Urbana Public Health District  
505 S. Fifth St., Champaign 61820  
P.T.—Sp.T.—N.C.

**CHARLESTON**

Charleston Community Memorial Hospital  
Rt. 130, Charleston 61920  
P.T.—Sp.T.—N.C.

**CHICAGO**

Alverna Home Nursing Center  
1437 W. 51st St., Chicago 60609  
P.T.—N.C.

Babette & Emanuel Mandel Clinic  
508 E. 29th St., Chicago 60616  
P.T.—O.T.—M.S.S.—N.C.

Cook County Dept. of Public Health  
1425 S. Racine Ave., Chicago 60608  
P.T.—N.C.

Drexel Home Inc.

6140 S. Drexel Ave., Chicago 60637  
P.T.—O.T.—M.S.S.—H.H.A.—N.C.

Jewish Home For Aged

1648 S. Albany Ave., Chicago 60623

P.T.—O.T.—Sp.T.—M.S.S.—H.H.A.—N.C.

Mt. Sinai Hospital Medical Center  
California Ave & 15th St., Chicago 60608

P.T.—O.T.—Sp.T.—M.S.S.—N.C.

Park View Home

1401 California Ave., Chicago 60622

P.T.—O.T.—Sp.T.—M.S.S.—H.H.A.—N.C.

Visiting Nurse Association of Chicago

5 S. Wabash Ave., Chicago 60603

P.T.—Sp.T.—M.S.S.—H.H.A.—O.T.—N.C.

**CLINTON**

DeWitt-Piatt Bi-County Health Unit  
122 E. Main St., Clinton 61727  
Sp.T.—N.C.

**DANVILLE**

Child Welfare and Visiting Nurse Association Inc.  
402 N. Hazel St., Danville 61832  
M.S.S.—P.T.—N.C.

Vermilion County Health Department

808 N. Logan Ave., Danville 61832

M.S.S.—N.C.

**DECATUR**

Visiting Nurse Association of Macon County  
1891 North Water St., Decatur 62523  
P.T.—O.T.—H.H.A.—N.C.

**DeKALB**

DeKalb County Health Department  
1731 Sycamore Rd., DeKalb 60115  
P.T.—Sp.T.—N.C.

**DES PLAINES**

Des Plaines Dept. of Public Health  
City Hall, Des Plaines 60016  
Sp.T.—P.T.—N.C.

**DIXON**

Lee County Health Department  
316 W. Third St., Dixon 61021  
P.T.—Sp.T.—N.C.

**EAST ST. LOUIS**

Visiting Nurse Assoc. of St. Clair County  
4601 State St., East St. Louis 62205  
P.T.—O.T.—Sp.T.—H.H.A.—N.C.

**EFFINGHAM**

Effingham County Health Department  
112 E. Section Ave., Effingham 62401  
P.T.—N.C.

**ELDORADO**

Egyptian Health Department  
1333 Locust St., Eldorado 62930  
Sp.T.—N.C.

**ELGIN**

Elgin Health Center  
370 E. Chicago St., Elgin 60120  
P.T.—N.C.

**EVANSTON**

Visiting Nurse Association  
828 Davis St., Evanston 60201  
P.T.—Sp.T.—H.H.A.—N.C.

**FLORA**

Clay County Health Dept.  
104½ W. Second St., Flora 62839  
M.S.S.—N.C.

**FREEPORT**

Stephenson County Health Dept.  
12 N. Galena Rd., Freeport 61032  
P.T.—N.C.  
Visiting Nurse Assoc. of Amity Societies  
7 N. State St., Freeport 61032  
P.T.

**GALENA**

Jo Daviess County Health Department  
311 S. Main St., Galena 61036  
P.T.—N.C.

**GOLCONDA**

Quadri-County Health Department  
Golconda 62938  
P.T.—O.T.—Sp.T.—N.C.

**GREENVILLE**

Bond County Health Department  
100 N. Locust St., Greenville 62246  
P.T.—N.C.

**HARDIN**

Calhoun County Health Department  
Sweeney Professional Bldg., Hardin 62047  
P.T.—H.H.A.—N.C.

**JACKSONVILLE**

Morgan County Health Dept. & Visiting Nurse  
Association  
234½ W. State St., Jacksonville 62650  
P.T.—H.H.A.—N.C.

**JERSEYVILLE**

Jersey County Health Department  
Courthouse, Jerseyville 62052  
P.T.—N.C.

**JOHNSTON CITY**

Franklin—Williamson Bi-County Health Dept.  
217 E. Broadway, Johnston City 62951  
P.T.—N.C.

**JOLIET**

Public Health Council  
102½ E. Van Buren St. Joliet 60432  
P.T.—N.C.  
Will County Health Department  
21 E. Van Buren, Joliet 60435  
P.T.—N.C.

**LaSALLE**

Hygienic Institute  
151 Fifth St., LaSalle 61301  
P.T.—N.C.

**LAKE FOREST**

Lake Forest Hospital Home Care Patients  
660 N. Westmoreland Rd., Lake Forest 60045  
P.T.—N.C.

**LAWRENCEVILLE**

Lawrence County Health Department  
Courthouse, Lawrenceville 62439  
P.T.—N.C.

**LINCOLN**

Abraham Lincoln Memorial Home Health Serv.  
315 Eighth St., Lincoln 62656  
P.T.—Sp.T.—N.C.

**MARSEILLES**

Marseilles Nursing Service  
S. Main St., Marseilles 61341  
P.T.—N.C.

**MOLINE**

Community Nursing Service of East Moline  
1409—7th Ave., Moline 61265  
P.T.—O.T.—Sp.T.—N.C.

**MORRIS**

Grundy County Health Department  
Courthouse, Morris 60450  
P.T.—N.C.

**MOUNT CARROLL**

Carroll County Health Department  
Courthouse, Mount Carroll 61053  
P.T.—N.C.

**MURPHYSBORO**

Jackson County Health Department  
1015½ Chestnut St., Murphysboro 62966  
Sp.T.—N.C.

**OAK LAWN**

Stickney Public Health District  
5636 State Rd., Oak Lawn 60459  
M.S.S.—N.C.

**OAK PARK**

Community Nursing Service of Oak Park & River  
Forest  
124 S. Marion St., Oak Park 60302  
H.H.A.—N.C.



### **OREGON**

Ogle County Health Department  
106 S. 5th St., Oregon 61061  
P.T.—N.C.

### **OTTAWA**

Ottawa Public Health Nursing Assn.  
417 W. Madison St., Ottawa 61350  
P.T.—N.C.

### **PARK FOREST**

Park Forest Public Health Nursing Service  
Village Hall, 200 F B, Park Forest 60466  
H.H.A.—P.T.—N.C.

### **PEKIN**

Home Care Program Pekin Memorial Hospital  
Court & 14th St., Pekin 61554  
H.H.A.—N.C.

### **PEORIA**

Peoria County Health Department  
2114 N. Sheridan Rd., Peoria 61604  
P.T.—Sp.T.—O.T.—M.S.S.—N.C.  
Visiting Nurse Assn. of Peoria and Peoria HC  
510 W. High St., Peoria 61606  
H.H.A.—O.T.—P.T.—M.S.S.—Sp.T.—N.C.

### **PETERSBURG**

Menard County Health Department  
Courthouse, Petersburg 62675  
H.H.A.—N.C.

### **PITTSFIELD**

Pike County Health Department  
Courthouse, Pittsfield 62363  
P.T.—N.C.

### **PONTIAC**

Livingston County Public Health Dept.  
419 Bank of Pontiac Bldg., Pontiac 61764  
P.T.—N.C.

### **QUINCY**

Adams County Health Department and Quincy  
Visiting Nurse Association  
333 N. Sixth St., Quincy 62301  
P.T.—M.S.S.—H.H.A.—N.C.

### **ROCK FALLS**

Whiteside County Board of Health  
201 W. First St., Rock Falls 61071  
P.T.—N.C.

### **ROCK ISLAND**

Rock Island Co. Dept. of Health  
County Courthouse, Rock Island 61201  
N.C.—P.T.—Sp.T.  
Rock Island Visiting Nurse Association  
1019—27th Ave., Rock Island 61201  
P.T.—Sp.T.—O.T.—N.C.

### **ROCKFORD**

Visiting Nurses Association of Rockford  
703 Grove St., Rockford 61108  
P.T.—H.H.A.—N.C.

### **SHELBYVILLE**

Shelby County Health Department  
123 N. Broadway, Shelbyville 62565  
P.T.—N.C.

### **SKOKIE**

Skokie Health Department  
5127 Oakton St., Skokie 60076  
P.T.—N.C.  
Visiting Nurse Assn., of Skokie Valley  
5255 Main St., Skokie 60076  
N.C.—P.T.—Sp.T.—H.H.A.

### **SPARTA**

Randolph County Health Department  
112 W. Jackson St., Sparta 62286  
N.C.—P.T.

### **SPRINGFIELD**

Visiting Nurse Assn. of Sangamon County  
730 E. Vine St., Springfield 62703  
N.C.—P.T.

### **TAYLORVILLE**

Christian County Health Department  
106 E. Main St., Taylorville 62568  
P.T.—Sp.T.—H.H.A.—N.C.

### **TUSCOLA**

Douglas County Health Department  
705 N. Main St., Tuscola 61953  
P.T.—N.C.

### **WATSEKA**

The Iroquois Hospital  
200 Fairman St., Watseka 60970  
N.C.—P.T.

### **WAUKEGAN**

Community Nursing Service of Lake County, Inc.  
1515 Washington St., Waukegan 60085  
N.C.—P.T.

### **WHEATON**

DuPage County Health Dept. & County Nursing  
Service  
222 E. Willow, Wheaton 60188  
P.T.—H.H.A.—N.C.

### **WILMETTE**

Wilmette Visiting Nurse Ass'n.  
905 Ridge Rd., Wilmette 60091  
P.T.—H.H.A.—N.C.

### **WINNETKA**

North Shore Visiting Nurse Ass'n  
614 Lincoln Ave., Winnetka 60093  
P.T.—N.C.

### **WOODSTOCK**

McHenry County Dept., Public Health  
209 N. Benton St., Woodstock 60050  
P.T.—Sp.T.—N.C.

### **YORKVILLE**

Kendall County Health Department  
County Courthouse, Yorkville 60560  
P.T.—N.C.

## DEPARTMENT OF REGISTRATION AND EDUCATION

William H. Robinson, *Director*  
Allen M. Andreasen, *Assistant Director*  
Edward Price, *Coordinator*,  
*Division of Professional Supervision*

The department is primarily concerned with the registration, licensing and enforcement of 31 laws governing the different professions, trades and occupations, including the Medical Practice Act. Enforcement of the Medical Practice Act is in the Division of Professional Supervision headed by a coordinator. Registration and licensing is under the jurisdiction of the Division of Registration.

The Medical Examining Committee appointed by the director of the department operates within the framework of the act and is charged with the responsibility of giving examinations for licensure, hearing complaints for revocation and suspension of licenses and promulgating rules and regulations for the administration of the act.

### Medical Examining Committee

Eugene Hoffman, D.C.  
George G. Jackson, M.D.  
William Johnson, M.D.  
William G. McCarthy, M.D.  
Dale E. Richardson, D.O.  
Kenneth H. Schnepf, M.D.  
Warren D. Tuttle, M.D.

### Medical Practice Act

#### LICENSING AND ENFORCEMENT PROCEDURES

Illinois statutes provide for licensing of physicians to practice medicine "(1) in all of its branches, and (2) licensing of those persons to treat human ailments without the use of drugs or medicine and without operative surgery."

The Medical Practice Act states, "no person shall practice medicine or any of its branches or midwifery, or any system or method of treating human ailments without the use of drugs or medicines, or without operative surgery, without a valid existing license so to do." Applicant for license must pass an examination of his qualifications which must be satisfactory to the Department of Registration and Education.

#### REQUIRED EDUCATION

Minimum standards of professional education: 2 years' course of instruction in a college of liberal arts or its equivalent, or in such medical college in a course of instruction in the treatment of human ailments which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months and in addition, a course of clinical training of not less than 12 months in a hospital. The college of liberal arts, medical school, and hospital must be reputable and in good standing in the judgment of the Department of Registration and Education.

All examinations provided by the Medical Practice Act shall be conducted by the Department of R&E. Examinations of applicants who seek to practice medicine in all of its branches which shall embrace the subjects of which knowledge is generally required of candidates for the degree of Doctor of Medicine by reputable medical colleges in the U.S., and shall be such in the judgment of the Department of R&E that will determine the qualifications of applicants to practice medicine in all of its branches.

Every license issued under the Act expires on July 1 of each even-numbered year. Every licensee under the Act may, biennially during the month of June of each even-numbered year, renew his license upon paying to the Department a renewal fee of \$10.

#### REVOCATION AND SUSPENSION OF LICENSE OR CERTIFICATE

The department may revoke or suspend the license, certificate, or state hospital permit of any person licensed under the act upon any of the following grounds:

- "1. Conviction of procuring or attempting or aiding to procure such an abortion as was made unlawful at the time under the Criminal Code of this State;
2. Conviction in this or another state of any crime which is a felony under the laws of this state or conviction of a felony in a federal court.
3. Gross malpractice resulting in permanent injury or death of a patient;
4. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud, or harm the public;
5. Obtaining a fee, either directly or indirectly, either in money or in the form of anything else of value or in the form of financial profit as personal compensation, or as compensation, charge, profit or gain for an employer or for any other person or persons, on the fraudulent representation that a manifestly incurable condition of sickness, disease or injury of any person can be permanently cured;
6. Habitual intemperance in the use of ardent spirits, narcotics, or stimulants to such an extent as to incapacitate for performance of professional duties;
7. Holding one's self out to treat human ailments under any name other than his own, or the personation of any other physician;
8. Employment of fraud, deception or any unlawful means in applying for or securing a license, certificate, or state hospital permit to practice the treatment of human ailments in any manner, to practice midwifery, or in passing an examination therefor, or willful and fraudulent violation of the rules

and regulations of the department governing examinations;

9. Holding one's self out to treat human ailments by making false statements, or by specifically designating any disease, or group of diseases and making false claims of one's skill or the efficacy or value of one's medicine, treatment or remedy therefor;
10. Professional connection or association with, or lending one's name to, another for the illegal practice by another of the treatment of human ailments as a business, or professional connection or association with any person, firm, or corporation holding himself, themselves, or itself out in any manner contrary to this Act;
11. Revocation or suspension of a medical license in a sister state.
12. A violation of any provision of this Act or of the rules and regulations formulated for the administration of this Act;
13. Except as otherwise provided in Section 16.01, advertising or soliciting by himself or through another, by means of hand bills, posters, circulars, stereopticon slides, motion pictures, radio, newspapers or in any other manner for professional business."

Section 16.01. Any person licensed under this Act may list his name, title, office hours, address, telephone number and any specialty in professional and telephone directories; may announce by way of a professional card not larger than 3½ inches by 2 inches, only his name, title, degree, office location, office hours, phone number, residence address and phone number and any specialty; may list his name, title, address and telephone number and any specialty in public print limited to the number of lines necessary to state that information; may announce his change of place of business; absence from, or return to business in the same manner; or may issue appointment cards to his patients, when information thereon is limited to the time and place of appointment and that information permitted on the professional card. Listings in public print, in professional and telephone directories, or announcements of change of place of business, absence from, or return to business, may not be made in bold faced type.

#### **Rules and Regulations Adopted for the Administration of the Illinois Medical Practice Act, Effective March 18, 1955**

##### **RULE 1—ACCREDITED COLLEGES OF MEDICINE AND SURGERY**

Medical colleges having rules and curricula commensurate with and equivalent to the rules and curricula of the College of Medicine of the University of Illinois, will be considered for accreditation by the Department of Registration and Education.

##### **RULE II—ACCREDITED COLLEGES TEACHING SYSTEMS OF TREATING HUMAN AILMENTS WITHOUT THE USE OF DRUGS OR MEDICINE AND WITHOUT OPERATIVE SURGERY.**

A professional college or institution teaching a system of treating human ailments without the use of drugs or medicine and without operative surgery shall be deemed reputable and in good standing in the judgment of the Department upon submission of proof of the following requirements:

(a) That a Dean or other Executive Officer, employed on a full-time basis supervises the students and curriculum.

(b) That the faculty is comprised of graduates in their specialty from recognized professional colleges or institutions.

(c) That the faculty is organized and each department has a director, professors, associate professors and assistant professors, each responsible to his superior for his instruction in the particular subject he teaches.

(d) That, annually, a catalogue or brochure is published setting forth the requisites for admission to the college, tuition rates, courses offered, dates of sessions, schedule of classes, requirements for graduation, a roster of the undergraduate students and a roster of the last graduating class. The catalogue or brochure shall contain a list of the departments of the school, the titles of the personnel and a brief summary of each person's qualifications. The curriculum shall include, but not be limited to, four academic years' instruction in the following subjects:

- (1) Anatomy
  - (a) Embryology
  - (b) Histology
  - (c) Neuro-anatomy
- (2) Physiology and Chemistry
- (3) Pathology and Bacteriology
- (4) Diagnosis
  - (a) Physical
  - (b) Differential
  - (c) Laboratory

(e) That suitable buildings provided with laboratories equipped for instruction in anatomy, chemistry, physiology, pathology, bacteriology and other areas of learning necessary to the due course of study prescribed by these rules; and that a laboratory equipped with supplies, models, manikins, charts, stereopticon, roentgen-ray and other special apparatus used in teaching the system to treat human ailments without the use of medicine and operative surgery, be provided.

(f) That a working library, easily accessible to students, is maintained from at least 9 a.m. to 5 p.m., with a librarian in constant attendance. The library shall contain a standard medical dictionary, the modern text and reference books, and the files of leading periodicals dealing with the particular system of treating human ailments without the use of medicine and operative surgery.

(g) That the college or institution requires all



students to furnish, before matriculation, satisfactory proof of the preliminary education required by the Medical Practice Act.

(h) That full and complete records are kept showing the credentials for admission, attendance, grades and financial accounts of each student.

(i) That admission of transfer students will be limited to honorably dismissed students from another approved college or institution teaching the same system. The transcript of record obtained directly from the transferring school shall be kept on file. It shall be the duty of a college or institution to furnish such a transcript for the benefit of each student subject to honorable dismissal. No credit shall be given a transferred student for final or "senior year" work or for any courses taken by correspondence.

(j) That students shall start class attendance within one week of the start of each session. That credit for completion of a course will not be granted a student who failed to attend 80 per cent of the complete session of the course.

#### RULE III—HOSPITALS APPROVED FOR INTERNSHIP.

1. A hospital shall, in the judgment of the Department be deemed reputable and in good standing for training interns and intern services when it meets the following standards:

(a) General hospital of 150 beds' capacity, with an average of at least 60 patients daily, with rotating service.

(b) Shall contain at least the departments of internal medicine, surgery, obstetrics and pediatrics; and an organized departmentalized staff, holding meetings monthly for case reviews and study.

(c) Laboratory employing a full-time qualified technician and at least a part-time qualified pathologist, visiting the laboratory at least two days per week.

(d) Radiological department employing a qualified X-ray technician and at least a part-time qualified roentgenologist, visiting the department at least two days per week.

(e) Maintenance of an up-to-date medical library located in a suitable study room available to interns.

(f) Such hospital shall provide and furnish the Department with the names of staff members of the various departments of the hospital.

(g) The hospital, upon the completion of a course of training therein of not less than twelve months, shall issue its certificate therefor to any such intern or at the request of the Department, such certificate shall include therein, by date, the commencement and the conclusion thereof.

2. An approved internship shall consist of twelve months rotating service in medicine, surgery, obstetrics and pediatrics, with an election in medical specialties.

In the event an applicant has received training in excess of the twelve months' period specified by the Medical Practice Act, and if this be in an institution approved by the Department as adequate for specialty training; and if the applicant has received certification by a recognized Medical Specialty Board, and has had two or more years' specialty practice or Military Service; such training and practice may be accepted as the equivalent of a rotating internship.

Any applicant who shall have completed twelve months of clinical training in a hospital, as required by Section 5-1(b) of the Medical Practice Act, and who has been accepted for further training in a specialty or general practice residency program by a hospital or institution approved by the Department for that purpose, shall be deemed to have complied with the requirements of this rule and of the Medical Practice Act in this regard.

#### RULE IV—APPLICATION FOR EXAMINATION

An applicant for examination for licensure to practice medicine in all of its branches, or any system of treating human ailments without the use of drugs or medicine and without operative surgery, must make application on forms furnished by the Department at least fifteen days prior to the examination and present, in addition:

(a) Recommendations from two (2) physicians duly licensed to practice in some state in the United States.

(b) A recent photograph, passport size, signed by applicant and the two persons licensed to practice the system of treatment of human ailments for which the applicant is seeking a license. A duplicate photograph must be presented with the card of admission at the examination.

(c) The original diploma of graduation from the professional college in which the applicant completed his course of training, or, in lieu of presenting the diploma with the application, the applicant may present it at the examination.

(d) A certified copy of secondary school and professional school studies to be mailed direct to the Department by the schools attended or by the professional schools where the applicant completed the required course of study.

(e) Proof of completion of a rotating internship of twelve months in an approved hospital for applicants seeking admission to examination for license to practice medicine in all of its branches; and, in the case of graduates of medical colleges in countries other than the United States and Canada, who apply for examination after January 1, 1953, proof of rotating internships of one year in approved hospitals in the United States.

A candidate under Section 5, paragraph 1b or Section 13, may apply for the examination or

clinical test and take the examination given immediately prior to completion of his internship provided he furnishes a statement from the hospital authorities stating his internship has been satisfactory to date. The results of the examination will be withheld and no license will be issued until the Department receives proof of satisfactory completion of the required internship in an approved hospital training program.

(f) Applicants who completed their medical courses in the extramural colleges of Ireland and Scotland shall not be eligible for admission to examinations for licensure under the Illinois Medical Practice Act.

(g) Graduates of European colleges or universities after January 1, 1943, with the exception of certain approved colleges in the British Isles, Denmark, Holland, Norway, Sweden and Switzerland, be not accepted for admission to examinations for licensure under the Illinois Medical Practice Act.

Graduates of such European medical colleges after January 1, 1943 may be considered for admission to Illinois examinations provided they present diplomas of graduation from approved medical colleges in the United States after attendance in such colleges for at least one year; and in addition, have served rotating internships of one year in approved hospitals in the United States.

(h) An applicant who presented a diploma of graduation from an approved school will not be accepted, if he was accorded advanced standing in such school based upon his prior education in an unapproved school.

#### RULE V—EXAMINATIONS

1. Examinations for licensure to practice medicine in all of its branches shall be conducted in the English language and shall be in the following theoretical and practical areas of medicine:

##### THEORETICAL

Chemistry  
Physiology  
Anatomy  
Pharmacology  
Pathology  
Bacteriology  
Medicine  
Public Health & Preventive Medicine  
Obstetrics & Gynecology  
Surgery  
Pediatrics  
Psychiatry

##### CLINICAL

General Practice of Medicine

2. Examinations for licensure to practice the treatment of human ailments without the use of drugs or medicine and without operative surgery shall be conducted in the English language and shall be in the following theoretical and practical subjects:

##### THEORETICAL

Chemistry & Physiology  
Anatomy & Histology  
Pathology & Bacteriology  
Diagnosis  
Hygiene & Medical Jurisprudence  
Eye, Ear, Nose, & Throat  
Dermatology, Pediatrics & Neurology  
System of Practice  
Obstetrics (of graduates of approved osteopathic colleges)

##### PRACTICAL

System of Practice

3. To be successful, applicants must receive general averages of 75% with no grade below 60 in the written examination, and a general average of 75% in the clinical or practical test.

Applicants applying for registration under Sections 12 and 12a of the Medical Practice Act shall be required to make general averages of 75% in the three subjects required for license to practice medicine and surgery in Illinois.

4. In case of failure in the first and second examinations applicants will be allowed credit on the following examination for all grades of 75 or more; but in case of failure in the third examination they must retake all written subjects at each subsequent examination. It is not required that the clinical or practical part of the examination be repeated after a passing grade of 75 has been received in that part of the examination.

5. Applicants who take the regular examination conducted by the Department for licenses as Physicians and Surgeons shall be excused from taking the clinical test.

6. An applicant for registration as Physician and Surgeon who has been unsuccessful in five examinations will be deemed to be eligible for further examination upon receipt of proof that he has completed one year of residency training in an approved hospital training program in the United States received subsequent to the applicant's fifth failure.

7. An applicant who has been unsuccessful in five examinations for registration as a drugless practitioner will be eligible for reexamination upon receipt of proof that he has completed a course of study of 960 hours in a school which is accredited under the Medical Practice Act. This course must be received subsequent to the applicant's fifth failure.

8. An applicant who furnished proof of a course of study of 240 hours in a school of chiropractic recognized by the Department in order to be eligible for further examination under Section 9a of the Medical Practice Act will be considered as a new applicant and his grades of 75 per cent or more will be carried over to the second and third examinations.



## RULE VI—RECIPROCITY

1. Each applicant for registration through reciprocity, either for the practice of medicine in all of its branches or for the treatment of human ailments without the use of drugs or medicine and without operative surgery, filed on forms provided by the Department, will be considered on its individual merits, provided the state or territory of original licensure grants a like privilege to persons licensed in Illinois.

2. If the application is not endorsed by officers of a state or county society it must be endorsed by two (2) physicians duly licensed to practice in some state in the United States.

3. Applicants for licensure through reciprocity or upon the basis of having passed the National Board Examination prior to January 1, 1964, must pass the clinical test conducted by this Department. Applicants upon the basis of the National Board Examination who completed Part III after January 1, 1964, are required to report for an interview with the Medical Examining Committee. The clinical test shall be such in the judgment of the Committee as will determine the qualifications of the applicant to practice medicine in all of its branches, taking into consideration the quality of medical education and clinical training or practical experience which the applicant has had, special honors or awards, publications in recognized and reputable journals, authorship of textbooks in medicine, and any other circumstance or attribute that the Committee accepts as evidence of an outstanding and proven ability in any branch of the field of medicine.

4. Graduates of Chiropractic colleges whose applications for registration in Illinois by reciprocity are approved, shall be required to pass a written examination in theory in addition to a practical test before the chiropractic examiner.

## RULE VII—LICENSURE

1. An examinee who successfully completes his medical examination must secure his certificate of licensure within one year from the date of his examination.

2. The Department will not issue a duplicate certificate of registration to practice medicine in all of its branches, or to treat human ailments without the use of drugs or medicine and without operative surgery, unless proof satisfactory to the Department and the Committee is presented that the original certificate was destroyed; or in case of change of name when the original certificate is returned for cancellation, together with satisfactory legal proof of such change of name.

3. A license to practice medicine in Illinois shall be a requisite for a residency in an Illinois hospital.

## RULE VIII—TEMPORARY CERTIFICATES OF REGISTRATION

1. Any person not licensed to practice medicine

in all of its branches in the State of Illinois who wishes to pursue a program of graduate or specialty or residency training in this State, must be the holder of a Temporary Certificate of Registration issued by the Department under the provisions of Section 11a of the Medical Practice Act of Illinois and in accordance with the provisions of the within Rules.

2. Application for a Temporary Certificate must be made on blank forms prepared and furnished by the Department. It must be submitted to the Department together with evidence satisfactory to the Department that applicant meets the requirements of Section 11a of the Illinois Medical Practice Act and that if his application is approved he will be accepted or appointed for the residency training in the hospital designated in such application.

3. A Temporary Certificate of Registration will be issued on behalf of an otherwise qualified applicant only for residency or specialty training in a hospital situated in this State which is approved by the Department for the purpose of such training. An approved hospital is one which in the judgment of the Department is qualified to offer such training, and which shall comply with the within Rules.

4. Written notice of the Department's final action on every application for a Temporary Certificate of Registration shall be given to the applicant and the hospital designated therein; when such application is approved the Temporary Certificate of Registration shall be delivered or mailed to the hospital designated therein and shall be kept in the care and custody of such hospital. The applicant shall not commence such specialty or residency training before he or the hospital receives written notification of approval of his application.

5. A Temporary Certificate of Registration shall not be valid for longer than one year after issuance thereof and may be renewed from time to time, in the discretion of the Department, for a period of not more than one year each time. Application for renewal must be made on forms prepared and furnished by the Department and the Temporary Certificate of Registration sought to be renewed must be submitted therewith to the Department.

6. When any person in whose behalf a Temporary Certificate of Registration has been issued shall be discharged or shall terminate his specialty or residency training in the hospital designated therein, such hospital shall immediately deliver or mail by registered mail to the Department his Temporary Certificate of Registration and written notice of the reason for return of same.

7. A Temporary Certificate of Registration is not transferable without prior notice to and approval by the Department. If the holder of a Temporary Certificate of Registration wishes to change to another training program in the ap-



proved hospital designated therein, or he wishes to enter a training program in another approved hospital, he must make application on Forms furnished by the Department. His current Temporary Certificate of Registration must accompany such application and he cannot thereafter continue in the training program designated on such current Certificate, and he may not commence such other training program until a Temporary Certificate of Registration has been issued therefor.

8. Not more than one Temporary Certificate of Registration shall be issued to any person for the same period of time. A person on whose behalf a Temporary Certificate of Registration has been issued is limited in the practice of medicine to the performing of such acts as may be prescribed by and incidental to his program of residency training in the hospital designated in his Temporary Certificate of Registration, and he cannot otherwise engage in the practice of medicine in the State of Illinois.

9. Whenever, under the within Rules, a hospital is required to deliver or return a Temporary Certificate of Registration to the Department, in case, because of the loss or destruction of such Certificate, or for any other reason, such hospital shall be unable immediately so to deliver or mail such Certificate, such hospital shall immediately mail or deliver to the Department a written explanation in detail of such inability.

10. The holder of a Temporary Certificate of Registration is not barred thereby from becoming eligible for admission to the Department examination for a license to practice medicine in Illinois if he otherwise meets the requirements for admission to such examination and if such person should fail to pass such examination such failure shall not bar him from completing his training program.

#### RULE IX—LIMITED LICENSES TO PRACTICE IN STATE HOSPITALS

1. Each application made on forms provided by the Department will be considered on its own merits.

2. The State Hospital at which the applicant will practice under the supervision of a medical officer, shall signify to the Department that the hospital will appoint the applicant in the event he receives a Limited License.

3. Any applicant for a Limited License who has failed in more than three examinations for licensure under the Illinois Medical Practice Act shall not be eligible for a Limited License.

#### ECFMG REQUIREMENTS

The Education Council for Foreign Medical Graduates (ECFMG) commenced operations in October, 1957. Sponsors of this agency are the American Hospital Association, American Medical Association, Association of American Medical

Colleges, and Federation of State Medical Boards of the United States. ECFMG gives two examinations a year to foreign medical graduates. The examinations test the graduate's general knowledge of medicine and command of English.

Persons successfully passing this examination are granted an ECFMG certificate. This certificate in the State of Illinois is **not a substitute** for nor is it the equivalent of licensure to practice medicine. It simply indicates that the holder's command of English has been tested and found adequate for assuming an internship in an American hospital. The holder of such a certificate may not practice medicine in any degree in a hospital in Illinois unless he is within one of the categories outlined above.

#### Offenses Listed

An unlicensed person who commits any of the following acts regardless of whether the same be committed within or without a hospital is guilty of practicing medicine without a license—a criminal offense:

1. Hold himself out to the public as being engaged in the diagnosis or treatment of ailments of human beings.
2. Suggest, recommend or prescribe any form of treatment for the palliation, relief or cure of any physical or mental ailment of a person with the intention of receiving therefor, either directly or indirectly, any fee, gift, or compensation whatsoever.
3. Diagnosticate or attempt to diagnosticate any ailment or supposed ailment of another.
4. Operate upon, profess to heal, prescribe for, or otherwise treat any ailment, or supposed ailment of another.
5. Maintain an office for examination or treatment of persons afflicted, or alleged or supposed to be afflicted, by any ailment.
6. Attach the title Doctor, Physician, Surgeon, M.D., or any other word or abbreviation to his name, indicative that he is engaged in the treatment of human ailments as a business.

(Section 24 *Medical Practice Act*. [Chp. 91, Sec. 16i, 1967 Rev. Stat.] )

Manifestly, the enforcement of the Medical Practice Act with respect to the elimination of unlicensed persons practicing medicine in a hospital is dependent upon co-operation by responsible persons within the hospital. It should be noted that lack of co-operation or failure to meet responsibilities can in a proper case be translated into criminal liability and disciplinary action resulting in revocation or suspension of a license to practice medicine as follows:

1. The unlicensed person practicing medicine is committing a criminal offense.
2. A hospital administrator who assigns an unlicensed person to duties which involve his

practicing medicine may subject himself to the criminal offense of aiding and abetting such unlicensed person to illegally practice medicine, and the same may be true of a hospital chief of staff or department head if in the nature of his duties he is directly responsible for assigning such duties to the unlicensed person.

3. A licensed doctor may have his license suspended or revoked if he has professional connection or association with another who is illegally practicing medicine. A chief of staff who knowingly allows such person to illegally practice medicine, or in a proper case, any member of the medical staff of a hospital may subject himself to disciplinary action against his license.
4. A licensed doctor may have his license suspended or revoked for unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public.

A member of the medical staff of a hospital may place himself within such conduct if he neglects, fails or refuses to fulfill his responsibilities while on emergency room call.

### Other Examining Boards

Other examining boards operating under the jurisdiction of the Department of Registration and Education are:

#### *Chiropody-Podiatry Examining Committee*

Dr. Charles H. Delano  
Dr. Theodore S. Hollingsworth

#### *Dental Examining Committee*

Dr. Eugene E. Ausbrook  
Dr. Hugh D. Burke

Dr. Ralph H. Council  
Dr. Herbert C. Gustavson  
Dr. Peyton Sidney Neuwirth  
Dr. Adrian L. Swanson

#### *Committee of Nurse Examiners*

Sister Mary Francis Cooke  
Mrs. Donna Hessler  
Mrs. Ina Ingwersen  
Mrs. Mary Lennan  
Mrs. Lillian G. Oertel  
Mrs. Harriet S. Olson  
Prof. Patricia Ann Wagner

#### *Optometry Examining Committee*

Dr. Jose E. Aponte  
Dr. Stanley F. Maer  
Dr. Irving C. Morgan  
Dr. Geve Ossello  
Dr. Floyd Woods

#### *Illinois State Board of Pharmacy*

John Barlow  
Joseph Davidson  
Louis Gdalmann  
Fred L. Janes  
Daniel Nona  
Harold W. Pratt  
Philip Sacks

#### *Physical Therapy Examining Committee*

James Mason Gray  
Mildred F. Andrews  
Vilma Evans

#### *Psychologist Examining Committee*

Dr. Philip Ash  
Dr. Roy Brener  
Dr. Wendell Dysinger  
Dr. Leroy A. Wauk

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## Medical Legal Information

Due to significant changes enacted by the 76th Illinois General Assembly and being considered by Gov. Richard B. Ogilvie, the Medical-Legal Section of the *Illinois Medical Journal*, Annual Reference Issue, has been delayed. This material was to have been considered by Governor Ogilvie as of September 15, after publication deadline. Accordingly, the Medical-Legal Section will appear in a future 1969 issue of the *Illinois Medical Journal*.

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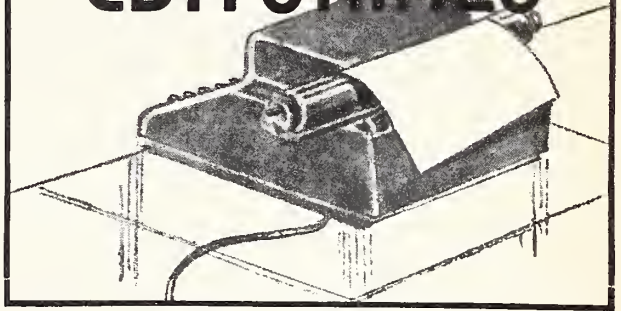
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# EDITORIALS



## **AUTOPSIES DECLINING IN ILLINOIS**

At a time when enormous resources are being expended for research to increase the store of medical knowledge as it relates to causes of death and diseases, it is surprising to discover that in Illinois the percentage of autopsies is apparently declining. Information taken from the 1968 death certificates shows a statewide autopsy per cent of 18.6 for medical cases and 18.4 for coroner cases, compared to 23.5 and 21.7 for 1967, and 23.6 and 21.1 for 1966. An autopsy rate of well under 10 per cent exists in some of the larger counties having one or more hospitals.

It is possible that some of this apparent decline may be attributed to the fact that in nearly 10 per cent of the cases the autopsy question on the certificate was left unanswered, but even taking that fact into consideration, it is estimated that the rate dropped about 3 per cent.

It is extremely important that the autopsy questions on the death certificates be answered in every case. It is the physician's or coroner's responsibility to supply this information, but the Illinois Department of Public Health has asked the funeral director to check this item and if he finds it unanswered, to query the physician concerning the answer.

The Illinois Department of Public Health considers this information valuable and urges every physician to conscientiously answer item 19 on the medical death records and every coroner to make certain that it is answered on the coroner's death record. Only in this way can it be determined whether or not the number of autopsies is increasing or declining.

Leo K. Ozier, Chief  
Bureau of Vital Records  
Ill. Dept. of Public Health

## **MALNUTRITION AND MENTAL RETARDATION**

There is malnutrition in infants and children in the state of Illinois due to hunger or inadequate diets. This has been established by the recent reports of many physicians and health authorities concerned with nutrition.

Health authorities have been stirred to action by a recent report of the United States Public Health Service of widespread malnutrition in Texas and Louisiana. Urgent action is needed because of the recent finding that severe malnutrition in early infancy can result in permanent impairment in brain development.

Winick,<sup>1</sup> an international authority on the effects of malnutrition on brain development, has pointed out that malnutrition results in a large pool of poorly functioning adults, who are destined to produce another generation of malnourished infants. Winick reported that during the first year of life the measurement of the head circumference correlates very well with size and number of cells in the brain. The degree of the reduction in the head circumference in malnourished infants is an indication of the severity of malnutrition.



What is urgently needed is a statewide survey of the actual number of malnourished infants and children. This is not easy to detect, since the type of malnutrition most likely to be seen is not the easily recognized severe types, but the borderline cases. Infant welfare clinics and well baby clinics will have to reemphasize the prevention and diagnosis of cases of malnutrition.

The recent passage of a bill to provide free meals to needy school children and the proposed "food prescription" program, which has been initiated by the Department of Human Resources of the City of Chicago in cooperation with the United States Department of Agriculture, are significant steps which could lead to the pre-

vention of malnutrition in Chicago.

The President's recent speech proposing legislation for a minimal annual income for needy families could result in the eventual elimination of malnutrition in the United States.

As Winick has aptly stated, "In view of the evidence linking malnutrition in infancy with permanent mental retardation, no responsible government can afford to tolerate malnutrition in its children."

Harvey Kravitz, M.D.

### Reference

1. Winick, M. and Rosso, P., "Head Circumference and Cellular Growth of the Brain in Normal Marasmic Children," *Journal of Pediatrics* 74:774 (May), 1969

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### Too Close For Comfort

The oft-heard warning that "history repeats itself" has an ominous meaning in the light of the book "The Decline and Fall of the Roman Empire." It was written in 1788 by Edward Gibbon and it sets forth five basic reasons why that great civilization withered and died. These were:

1. The undermining of the dignity and sanctity of the home, which is the basis for human society.
2. Higher and higher taxes; the spending of public money for free bread and circuses for the populace.
3. The mad craze for pleasure; sports becoming every year more exciting, more brutal, more immoral.
4. The building of great armaments when the real enemy was within—the decay of individual responsibility.
5. The decay of religion; faith fading into mere form, losing touch with life, losing power to guide the people.

The average age of the world's great civilizations has been 200 years. These nations progressed through this sequence;

From bondage to spiritual faith; from spiritual faith to great courage; from courage to liberty; from liberty to abundance; from abundance to selfishness; from selfishness to complacency; from complacency to apathy; from apathy to dependence; from dependence back again to bondage.

In a few years the U.S. will be 200 years old. This cycle is not inevitable—it depends on you.

Virginia Medical Monthly

### New Medical Schools

The Nation will have 101 medical schools when two new schools open this fall. Schools are Louisiana State U. Medical Center, Shreveport, and Medical College of Ohio, Toledo. With 32 expected to enroll at each new school, total first-year students in U.S. schools is estimated at 10,012. (AMA Newsletter, 1:16 (Sept. 1) 1969, pg. 2)

## ***Contraceptive Practice Faulty Among Middle-Class Coeds***

Almost 40% of unmarried coeds at Oberlin College (Oberlin, Ohio) reported in a student health survey that they had had sexual intercourse. One out of 13 of these young women became pregnant. More than half of them reported they had made no use of any birth control method.

These findings were reported by Alan Wachtel, a medical student at New York's Mt. Sinai School of Medicine.

The survey of health practices of Oberlin's undergraduate female population proposed that these young women of affluent backgrounds (63% of the freshmen estimated their parents' annual income at between \$10,000 and \$25,000) "need more effective contraceptive education, along with counselling and medical care," Mr. Wachtel maintained. As an undergraduate at Oberlin, Mr. Wachtel was chairman of the student committee which conducted the survey.

The survey (based on 1967 studies) showed that even when the girls used birth control, they relied upon the less effective, non-prescription methods such as foam, rhythm, and the condom.

### **Coeds and the Pill**

The older the girl, according to Mr. Wachtel, the more likely she was to use the

oral contraceptive. Just over 20% of incoming freshmen used the pill regularly, compared to between 36 and 46% of upper classmen. Similarly, only 1.6% of the incoming freshmen used the diaphragm regularly, compared to 8.3% of seniors.

Of the women with coital experience, 187 or 39% indicated that they had obtained contraception by a doctor's prescription. But almost 60% had consulted a doctor other than a family physician, a member of the college health service, or one practicing in the community close to the college. This means they did not have access to ongoing, regular medical care in connection with contraception, according to Mr. Wachtel.

Non-prescription methods purchased in drug stores were used by half the girls with coital experience, while 10% obtained contraception items from parents or friends.

### **Partial Education**

Mr. Wachtel said the study showed that these coeds, an intelligent, economically and socially privileged group, had not received complete sex education, including contraceptive education. They appeared to have no ongoing contact with a physician to whom they could turn for counselling and service.

## ***Film Reviews***

"Poison," a 14-minute, 16mm. color film demonstrates that the natural and avid curiosity of children, sometimes leads to unnecessary poisoning, and that such an event can be avoided only by the care and diligence of parents. The similarity between harmful and harmless common household products is stressed.

The film effectively points out the haphazard way in which poisonous household products are stored. Also included in the film are measures to prevent and to counteract poisoning of small children. This film, recommended for use by PTA groups, community, service and safety organizations and hospitals with training classes for parents, may be ordered from: International Film Bureau Inc., 332 S. Michigan Ave., Chicago 60604.

"In the Service of Man," a 12-minute, color-sound film dramatizes the role of nonwoven disposables in support of surgical asepsis.

The advantages of non-woven fabrics over linen surgical drapes are discussed in the film with special emphasis on the moisture resistance and convenience. Orders should be sent to: Convertors, 110 Edison Place, Newark, N.J. 07102.

"Early Diagnosis and Management of Breast Cancer" is a new professional education film for practicing physicians and medical students. It covers the characteristics of breast cancer as related to early diagnosis and complete management. This 16 mm. or 8 mm. color and sound film has a running time of 19½ minutes and is available from your local Division or Unit of the American Cancer Society.

# Rx Products Index

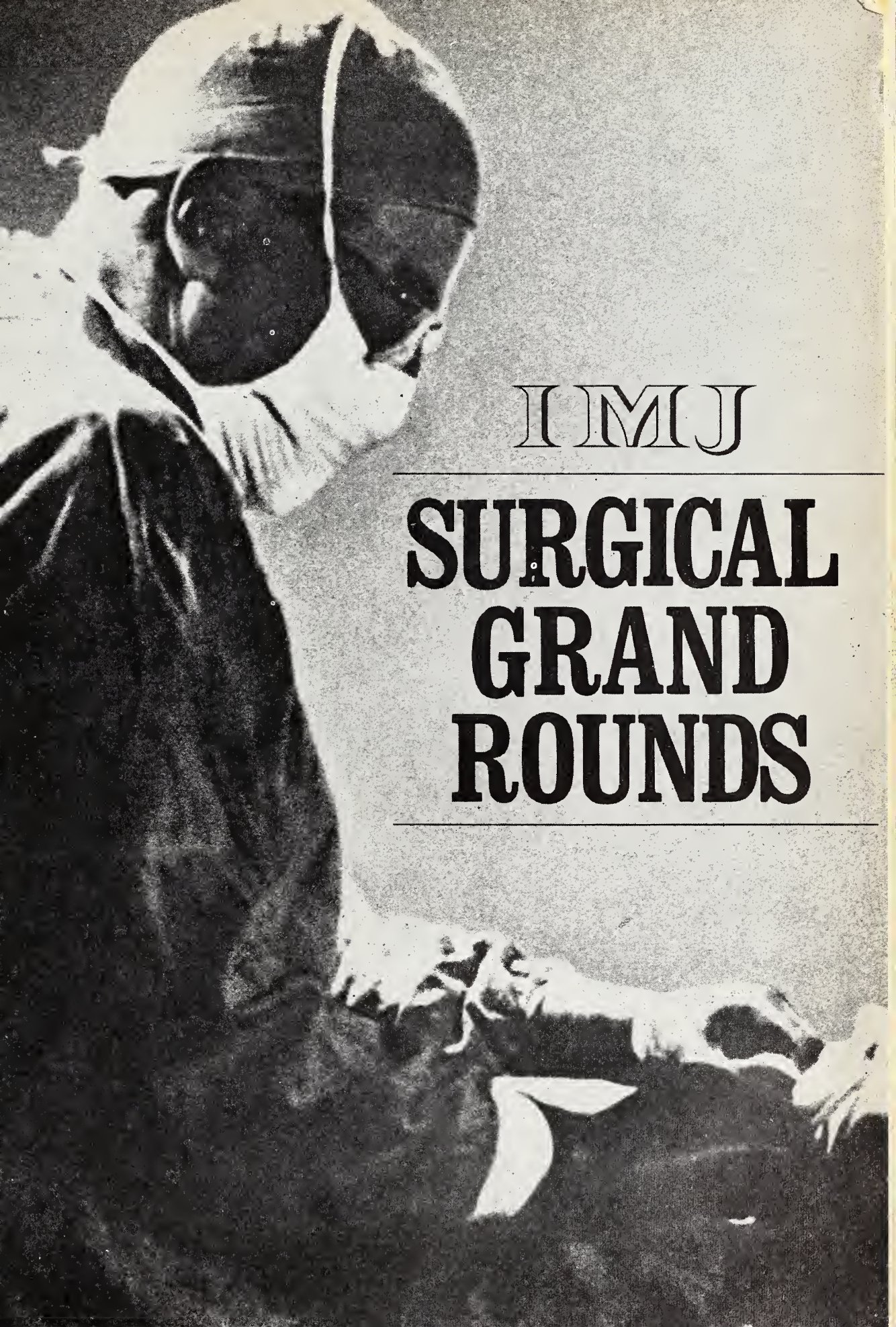
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## Journal Advertising

The subscription price of the *Journal* is some 70 per cent less than cost because of income derived from pharmaceutical advertising. This fact does not affect the *Journal's* contents but has been criticized as influencing medical practice to the advantage of the industry and disadvantage of the patient.

Advertising is a fact of capitalistic life, and it is inherently prejudiced, not objectively educational. Suggestions that it be totally eliminated from the *Journal*, subjected to the same stringent review applied to scientific manuscripts, or meticulously censored are impractical and unrealistic. For the moment, medical journals should amplify the information they publish about drugs so that physicians need not depend on advertisements for such information. In the future, the adoption of pharmaceutical promotional practices acceptable to all will depend on the establishment of better rapport and greater co-operation among industry, government, and the medical profession. (Annual Discourse—Swinging Copy and Sober Science. Franz J. Ingelfinger. *New England J. of Med.*, 281:10 [Sept. 4] 1969, pp. 526-532.)





I M J

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**SURGICAL  
GRAND  
ROUNDS**

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# Parotid Tumor



**Fig. 1** This specimen consisted of half of the mandible with attached tumor.

EDITED BY JOHN M. BEAL, M.D.

*Surgical Grand Rounds are held weekly on Saturday at 8:00 a.m.; alternating between the Staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds held at Passavant Memorial Hospital on March 22, 1969.*

## **CASE REPORT:**

**Dr. Peter Jansons:** A 38-year-old lawyer was admitted to Passavant Memorial Hospital with progressive "stiffness" in the right jaw of 6 months duration. Associated with stiffness of the jaw, he developed intermittent numbness in the right mental area.

He had developed frank trismus by February, 1969, and a month later a palpable mass was noted at the right angle of the mandible. He was therefore admitted March 4, 1969. During the preceding 6 months he had seen several physicians, had received antibiotic therapy, and had his third molars extracted, all without improvement.

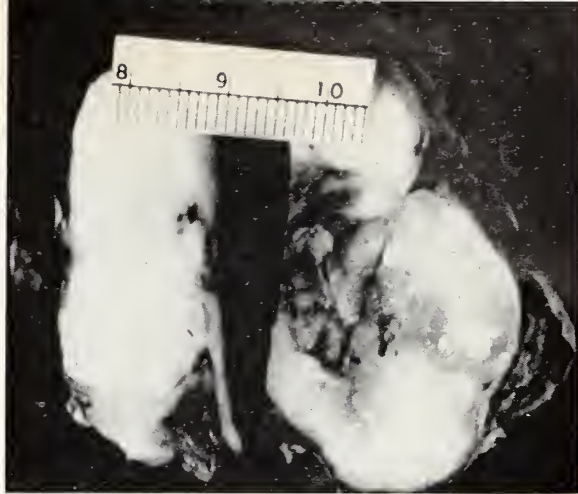
Physical examination disclosed that he had trouble opening his mouth. Inspection of the pharynx revealed fullness on the right side posteriorly and the tonsillar folds were erased. A mass was palpable deep to the muscles on the right side of the pharynx. Cervical adenopathy was not present and a mass was not felt at the angle of the mandible.

The laboratory values were all within normal limits as were X-rays of the mandible.

On March 5, he was taken to the operating room where a biopsy of the mass was obtained. Two days later radical resection of the mandible was performed.

**Dr. Joseph Sherrick:** The specimen received included half the mandible, as shown in Fig. 1. At the left-hand side of the photograph, one can see the nodular tumor projecting from behind the mandible. Fig. 2 shows the cut surface of the tumor, which appears to be encapsulated and consists of firm, pale gray tissue which is partly mucinous. Microscopically, in Fig. 3, one sees the peculiar stroma and the distorted glands of a mixed tumor, here shown invading the capsule. In other areas, the tumor was much more cellular, with many pleomorphic large, round cells with pale cytoplasm. In Fig. 4 these cells are seen invading adjacent skeletal muscle. The invasion of the skeletal muscle, the cellularity and the pleomorphism support our opinion that this is a malignant mixed tumor or pleomorphic adenocarcinoma of the parotid gland.

**Dr. Orion Stuteville:** I believe in every case report there should be a specific lesson. The lesson to be learned from this patient was that he came in with a story and the story gave the diagnosis. This story began in May, 1968, at which time he turned over in a boat in a lake, after which he had an infection in the ears. He visited a physician who treated him for this infection which resolved promptly. Unfortunately,



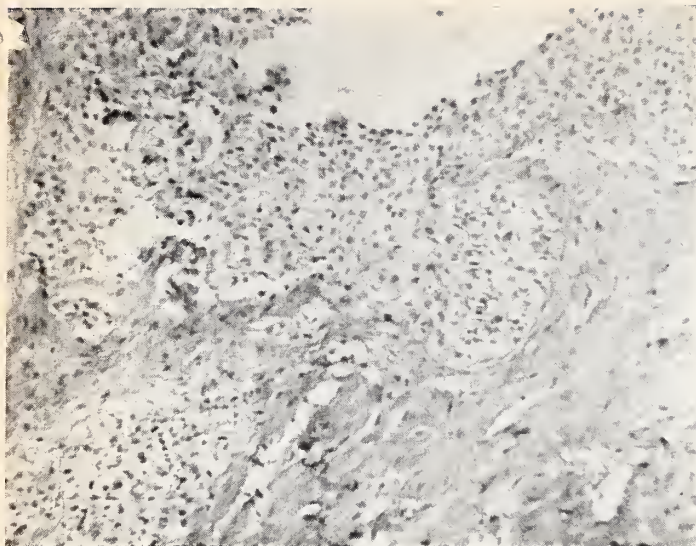
**Fig. 2** The tumor appeared to be encapsulated when sectioned.

this became a "red herring" in the case history. In July, 1968, he complained of pain in the right ear which was quite bothersome. He returned to the physician who gave him another course of medication after examining his ears, although apparently evidence of infection was lacking. During the course of medication, the pain in the ear and the jaw improved, but did not disappear. A month later the pain persisted and he began to develop stiffness in the jaw. His physician referred him to a dentist feeling that it could be the teeth which were causing the trouble. His teeth were cleaned and he was given another course of antibiotics without benefit.

In late August, he began having numbness in the lower lip which changed from tingling to numbness to pain and then a return to complete sensation. When he complained of these findings to the dentist, he was referred to an oral surgeon who took X-rays and discovered an impacted lower 3rd molar which was removed. Following the removal of the lower third molar, he had a severe episode of swelling and stiffness of the jaw to the point where he could not open his jaw to chew. He therefore had to live on a liquid diet. This persisted for about two weeks in spite of antibiotics and other medication. In September, the jaw was stiffer and he continued to have numbness in the lower lip associated with episodes of pain and severe stiffness of the jaw. He returned to his physician who referred him back to the oral surgeon, and together they gave him another course of antibiotics without relief. This continued on through December and January.

In February, he complained of severe dif-





**Fig. 3**  
Microscopic examination demonstrated peculiar stroma with distorted gland, consistent with a diagnosis of malignant mixed tumor of the parotid gland.

ficulty with stiffness of the jaw on the right side with an area of numbness in the lower lip which he described as the size of a half dollar. He was referred to a head and neck specialist. When he gave this specialist his story written out on a piece of paper, the reaction of the specialist was that he should see a psychiatrist, that he was a hypochondriac looking for sympathy. Therefore, he explained to the patient that the stiffness was most likely produced by the injection given by the oral surgeon for the anesthetic when he removed the lower wisdom tooth, although the patient made note that all these symptoms started before the injection by the oral surgeon. He returned to his doctor who advised him to obtain another opinion. This is where we came into the picture.

If we analyze this man's story, we find that his first complaint of infection in the ears caused by overturning in his boat in the lake had nothing to do with his real complaints. If we start with the beginning of his story of having stiffness of his jaw with referred pain to his ear, we would think in terms of some involvement of the inferior dental nerve. This could have been produced by some infection around the lower third molar. The removal of the lower third molar was not a fiasco as it were in this stage of his story. However, after the tooth had been removed and the swelling had gone down, he continued to have more stiffness, pain, numbness, and tingling which fluctuated from tingling, to numbness, to pain, and to return sensation

involving only the inferior dental nerve and reflected over the mental nerve. This did not involve the lingual nerve. Therefore, this puts the lesion in the pterygomandibular fossa below the area where the lingual nerve branches off the third division. This must put the trouble between the medial pterygoid muscle and the ramus of the mandible.

Due to the fact that his symptoms fluctuated from tingling to numbness to pain to return of sensation, we must think in terms of a lesion which is secreting fluid and the fluid is being resorbed. In other words, when the fluid is being secreted there is pressure producing the sensation of tingling. As the pressure increases, it becomes pain and as it increases further, it produces total numbness. When the fluid is resorbed, the sensation returns to normal. As the pressure built up over a period of time, he eventually developed an area of numbness over the mental branch which then tells us there is a lesion in the pterygomandibular fossa probably of a secreting nature and probably in the deep lobe of the parotid gland.

Our preoperative diagnosis was a tumor of the deep lobe of the parotid gland in the pterygomandibular fossa, and due to the fact that we could not feel the tumor on the outside, we approached the mass from the intraoral route to the pterygomandibular fossa where we found a tumor deep in the pterygomandibular space between the medial pterygoid muscle and the ramus of the mandible. Frozen section was reported as a carcinoma. Because we had promised the patient that we would only make a diagnosis at the first exploratory procedure, we closed the incision and performed a definitive operation at a later time.

The story here to be learned is that: 1) is good to be "the low man on the totem pole" after everyone else has made all the mistakes. When we benefit from their mistakes, then we can make astute diagnoses. 2) We should listen to the patient's story carefully and many times the patient will give us the diagnosis as in this case.

## PATIENT ENTERS

As you notice, the operative approach involved a wide flap in order to get into the pterygomandibular space and the infratemporal fossa. We reflected the masseter

muscle and all of the tissues off the mandible, then sectioned the mandible at the first bicuspid region. The entire contents, including the medial pterygoid muscle, the contents of the pterygomandibular space, and the infratemporal space along with the parotid gland was removed. After cleaning out the entire tumor bearing area, the flap was returned, the mucosa closed, suction was placed beneath the flap, and wires were placed on his teeth to immobilize his jaw and keep his mandible from drifting in the postoperative period. In about six weeks, he will have a prosthetic appliance constructed in order to control the position of his mandible. If he has no trouble in the next 18 months or 2 years, we will entertain the thought of reconstructing his mandible with a bone graft.

#### PATIENT LEAVES

**Dr. Casey:** The deep lobe of the parotid is not a separated thing like lobes of the lung. The gland is folded around the posterior margin of the mandible. I think right now of five, by name, whose tumor arose within this deeper portion of the gland. Nobody has separated them categorically as to their origin, deep or superficial. I find that being able to palpate a deep lobe tumor through the lateral pharyngeal wall is exceedingly difficult, and that it's quite a rarity, as in this case, to be able to palpate it medially. It has been estimated that those tumors that arise within this portion of the gland which is approximately a fifth of the bulk of the gland and which

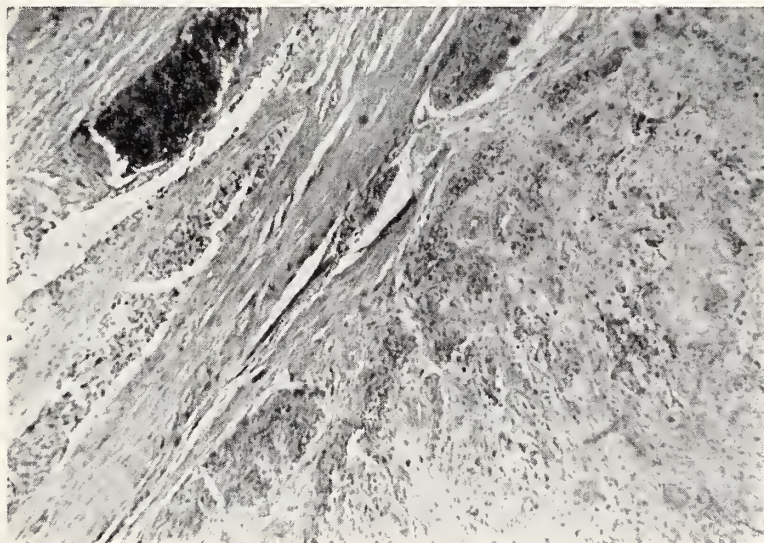
lies medial to the Ramus of the mandible represent 10% of the total of parotid tumors.

**Dr. Beal:** I had the impression that when there is nerve involvement that you are dealing with a malignant lesion. Is that correct?

**Dr. Griffith:** Benign tumors of the parotid do not invade the nerves. If the nerve is involved, the tumor is malignant. This is true virtually without exception. One exception, though, was a patient we had several years ago who had an enormous mass in the region of the parotid which proved to be Paget's disease of the skull and mandible of many, many years standing. It had become so large and was so hard that it had stretched his facial nerve to the point where he had paralysis. After the mass had been reduced in size, the facial nerve function returned.

**Dr. Casey:** I think there's one point which we haven't mentioned. First, this is a phenomenally beautiful result. Having seen the surgical specimen one was prepared to cringe at the patient's appearance. It's expected that a malignant tumor (which was the preoperative diagnosis) often requires sacrifice of the facial nerve. Here, with a wide margin of tissue resected, it's worthwhile to recognize that the operation fits the patient. He did not lose facial nerve function with resulting watering of the eye and a deformed face. He has had only a necessary sacrifice of muscle, bone and gland recognizing where the tumor arose. ◀

**Fig. 4** Malignant cells were demonstrated to invade adjacent skeletal muscle.





## Making Nitre

An example of man's ingenuity is illustrated in the sad plight of Selma, Alabama during the Civil War, an account of which is given by William Homer Smith. The shortage of nitrogen for the production of gunpowder was acute. It occurred to John Harrolson that a unique source might be available. Notices were posted through the town as follows:

"The Ladies of Selma are respectfully requested to preserve the camber lye collected about the premises for the purpose of making nitre. A barrell will be sent around daily to collect." John Harrolson, Agent Nitre Mining Bureau.

Amused by the notice the Southern soldiers composed the following song:

### HE ADVERTISED FOR CHAMBER LYE

John Harrolson! John Harrolson! You are a wretched creature.  
You've added to this bloody war a new and awful feature.  
You've have us think while every man is bound to be a fighter,  
The ladies, bless the dears, should save their P for nitre.  
John Harrolson! John Harrolson! Where did you get the notion?  
We thought the girls had work enough making shirts and kissing,  
But you have put the pretty dears to patriotic pissing.  
John Harrolson! John Harrolson! Do pray invent a neater  
And somewhat more modest way of making your saltpeter;  
For 'tis an awful idea, John, gunpowder and cranky,  
That when a lady lifts her shift she's killing off a Yankee.

When the Northern soldiers learned of this they countered their own ditty:

### THE YANKEE VIEW OF IT

John Harrolson! John Harrolson! We've read in song and story  
How women's tears through all the years have moistened fields of glory.  
But never was it told before amid such scenes of slaughter  
Your Southern beauties dried their tears and went to making water.  
No wonder that your boys are brave, who couldn't be a fighter  
If every time he fired his gun, he used his sweetheart's nitre;  
And vice-versa, what would make a Yankee soldier sadder  
Than dodging bullets fired from a pretty woman's bladder:  
They say there was a subtle smell that lingered in that powder,  
And as the smoke grew thicker and the din of battle louder,  
That there was found to this compound one serious objection,  
No soldier boy could sniff it without having an erection.  
("Evolution of Urology: Some Famous Personalities with Urological Disorders." Meyer M. Melicow, *Urological Survey*, Vol. 18 (Aug.) 1968, pg. 199-214.)

*Ed. note: Membership Forum is a means for the ISMS physician to express opinion and viewpoint on varied topics. If you have an item you would like brought before your fellow practitioners, please submit it to Membership Forum, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601. Communications should not exceed 250 words. The right to abstract or edit is reserved. Names will be withheld upon request, but anonymous letters will not be accepted.*

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**When is a handicap  
not a handicap?  
When a deaf Beethoven  
composes a symphony.  
When an average guy  
with a disability does  
his job well.**

**The Presidents Committee  
on Employment of the Handicapped  
Washington, D.C. 20210**



# SOCIO ECONOMIC *news*

*A service of the Public Relations and Economics Division*

By JOSEPH J. LOTHARIUS

## **37 Per Cent of ISMS Members Answer Survey**

A record-breaking response to ISMS-1969 "Survey On Major Issues" reflected the opinions of more than one third of our membership. Computer tabulations of the 3,550 responses (THE ENTIRE SURVEY RESULTS WILL BE ANALYZED IN NOVEMBER AND DECEMBER *IMJ* ISSUES) show more than 92 per cent of the replies favor reducing hospital stays by handling all diagnostic workups on an outpatient basis (provided the patient's condition permits and insurance coverage is available). Ninety six per cent would prefer to perform minor surgery on an outpatient basis to help reduce hospital use, and over 95 per cent felt insurance carriers should be encouraged to provide comprehensive coverage, including outpatient and home care.

\*\*\*\*\*

## **"Feldshers" Not Wanted**

The majority of physicians responding to the Survey (61.5 per cent) oppose the use of trained and licensed "doctor's assistants" or "feldshers" to work in their offices performing routine duties, such as preliminary screening for illness, well-baby examinations and family planning.

\*\*\*\*\*

## **Med Journals Favored For Drug Information**

Survey results showed Illinois physicians listed scientific articles in medical journals as their chief source of drug information. The second chief source was from medical meetings; third was PDR (Physicians' Desk Reference); and the fourth choice was drug company detail men. Other alternate choices in their order of preference were: advertisements in medical journals, direct mail advertising, and the FDA releases (Dear Doctor letters).

\*\*\*\*\*

## **Deducting IDPA Patients From Income Tax**

ISMS members were more evenly divided on the question—As an alternative to billing IDPA, would you be willing to treat public aid (medicaid) patients at no cost if the internal revenue act would be amended to authorize deducting these bills when calculating income taxes? Some 54.5 per cent voted yes and 45.5 were opposed.

\*\*\*\*\*

## Fee Rise Higher Than Cost of Living

*Medical Economics* reports that physicians' fees rose 4.3 per cent nationally during the first half of 1969—a steeper rise than in either half of 1966, the year Medicare came in and the peak year for upward fee adjustments by physicians. The report stated that Consumer Price Index figures, the overall cost of living, rose 3.2 per cent in the first six months of this year. Meanwhile in the Chicago area, the Consumer Price Index reports a rise of 18 per cent for all items during the past decade. The medical care index in Chicago was up 53 per cent during this period, almost three times faster than the over-all index. Nationally, for the same period, there was a 21 per cent increase for all consumer items and a 45 per cent rise for medical care.

\*\*\*\*\*

## Free Medical Clinic Opens

A new free inner city community medical clinic opened recently in Chicago and will provide non-surgical pediatric and basic adult medical care. The clinic, which will be open five days a week, is operated by the University of Illinois College of Medicine and will serve an area immediately south of the West Side Medical Center campus. A \$71,400 grant from the Illinois Regional Medical program will support the clinic. The Regional Medical program, federally funded, but locally operated, seeks to close the gap between knowledge available and its application. It particularly encourages medical school involvement in improving health care delivery.

\*\*\*\*\*

### YOUR ISMS INSURANCE QUESTIONS

**QUESTION:** I maintain a medical laboratory in connection with my office. Does my ISMS policy afford liability protection for this exposure?

**ANSWER:** If the laboratory facilities are for the physician's own use and do not constitute a separate business enterprise, the laboratory is covered.

*Do you have a question of general interest on any ISMS-sponsored insurance program: Retirement Investment, Keogh, Group Disability, Group Major Medical, Professional Liability (Malpractice)? Send it to this column: "Your ISMS Insurance Questions," Illinois Medical Journal, 360 N. Michigan Avenue, Chicago, Ill. 60601. The column is a service of the ISMS Committee on Medical Economics and Insurance.*

"In young people's circles, the term Organization Man is uttered with derision. Instead of being the enemy of liberty and freedom, I contend the Organization Man is the one who keeps our free society functioning. So I tip my hat to him."—Thomas Howarth, chairman, Board of Regents, National Chamber Institutes for Organization Management.



## Help For The Busy Physician

By RUBY JACKSON/CHICAGO

It should be obvious that the more knowledge and training your assistant has the more help she can be to you in running a more productive and efficient office. Yet many physicians employ an aide who has not had training or any special qualifications for her job.

We are not recommending that all such assistants be forthwith discharged, but all such employees can be greatly aided by one simple and pleasant step—membership in the Illinois Medical Assistants Association.

Membership in this organization confers many immediate and practical benefits, both to the medical assistant and to her employer, such as:

1. Continued education and professional stimulation. Proven methods of efficient operation and office management techniques are provided by annual national and state meetings, seminars and educational symposiums. Advice may be obtained regarding individual problems through personal attention from the office of the American Association of Medical Assistants. This saves the doctor much time and energy he might expend in such training.

2. Affiliation with others with interchange of ideas on how to be a better medical assistant.

3. The Illinois Medical Assistants Association Newsletter, a professional journal which carries articles of interest to medical assistants and news of I.M.A.A. activities.

4. Comprehensive group insurance program—providing life insurance, in-hospital indemnity, major medical coverage and income protection. (sick pay insurance)

5. Increased status and prestige for the medical assistant.

6. New friendship and fellowship with others in various communities with I.M.A.A. chapters.

Obviously, no one has more to gain through membership in the Illinois Medical Assistants Association than does your assistant, with the possible exception of you, Doctor. Although your assistant may be just what you ordered, perhaps a little extra finesse can turn her into an unbelievable find!! Imagine what this can do to improve her efficiency, your public relations and an otherwise hectic day!

Thus, it behooves every member of the Illinois Medical Society to urge his medical assistants to become members of an organization dedicated to better service to his profession and the public.



## *Looking for a Place to Practice?* *Placement Service Lists Openings*

In an effort to reduce the number of towns in Illinois needing practicing physicians, the *Journal* is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

**TAZEWELL COUNTY:** Hopedale; population: 750. Trade area: 15,000. The Hopedale Medical Complex (Hopedale Hospital, Hopedale Nursing Home, Hopedale House for the Elderly and Hopedale Rehabilitation Center); G.P. or internist preferred. To serve as key man in the complex. Independent practice. Support from 11 G.P.s. One board surgeon on staff. All specialties available from nearby large cities. Hospital clinical lab, x-ray dept. and complete outpatient pharmacy with full time registered Phar. and full time dentist. Three universities, boating, sailing, country club with large pool less than 1/2 hr. away. New consolidated school district to have finest high school in downstate Ill. Catholic, Protestant, Mennonite churches. Could have office in Complex or in town. For further information contact: Edward W. Gilan, Administrator or L.J. Rossi, M.D., Medical Director; Phone: 309-499-3321.

**UNION COUNTY:** Jonesboro; population: 1,700. County seat. Town without a physician since 1960. Nearest hospital at Anna, 3 miles. One hundred miles from St. Louis. One local pharmacy. Sources of income: agriculture, livestock, lumber mills and shoe factory in neighboring town. Churches: Baptist, Lutheran, Methodist and Pentecostal. Grade and high schools. Excellent facilities for fishing, hunting and

boating. Gulf, Mobile and Ohio railroad. Shawnee National Forest. Office of Tri-County Health Dept., Association of Nurses, Union Co. Farm Bureau, etc., located here. For further information contact: Mr. Fred Foehr, Jonesboro.

**VERMILION COUNTY:** Danville; population: 50,000. Twenty-nine general practitioners; average age 53. Total physicians in county: 60. Three hospitals. Five hundred beds. Agriculture and industry. Ninety churches; 24 major denominations. Twenty-five grade schools, 3 Jr. highs, 2 high schools, Jr. college. Three country clubs, 6 golf courses, 3 swimming pools, 10 parks. Good fishing and boating facilities. For further information contact: Thomas E. Pollard, M.D., 917 N. Walnut, Danville 61832; Phone: 217-442-0911.

**VERMILION COUNTY:** Ridge Farm; population: 900. Trade area: 2,500. Town without a physician for 5 years. Nearest physician 5 miles. Fifty miles from Champaign. One prescription drug store. Financial assistance can be provided. Predominant nationality: German and English. Sources of income: agriculture and industry. Methodist, Nazarene, Quaker, Christian and Church of Christ. Grade and high schools. Community recently surveyed Sears Foundation, shows good economic potential. For further information contact: Steve Kelley, 3 South State, Ridge Farm; Phone: 247-2272 or 247-2438.

**VERMILION COUNTY:** Rossville; population: 1,500. Trade area: 3,200. One physician, age 65, trying to retire. Second physician retired recently. Nearest hospital, 7 miles. Twenty miles from Danville, population 50,000. Attractive office and home of retired physician available if desired. Agricultural area. Many residents employed in factories in nearby towns. Churches: Presbyterian, Methodist, Church of Christ, Baptist and Nazarene. Grade and high schools. Excellent country club with golf course and pool. One hundred fifteen miles south of Chicago. C&EI RR. For further information contact: Mrs. Harold Cornell, Rossville; Phone: 748-3182.

# Terramycin<sup>®</sup> (oxytetracycline)

Fire victim. Examination reveals second degree burn of lower leg. To combat shock, restore circulatory volume and replace protein loss, plasma is administered. Local pressure dressing applied. Limb elevated to limit the flow of lymph. About 36 hours after admission the patient develops an elevated temperature and complains of pain at the site of the lesion. Dressing removed. A suppurating slough area has developed over part of the burn. A swab specimen is taken for culture and the slough area is debrided. Antibacterial treatment is begun with Terramycin I.M. Days later, recovery is progressing, and the laboratory report shows a mixed infection with a predominance of susceptible coliform bacteria, confirming the therapeutic choice. Terramycin therapy is continued until all signs of infection disappear.

Experience has shown that Terramycin offers special advantages in treating bacterial infections complicating burns, when strains of causative organisms are susceptible. Broad-spectrum antibacterial coverage. Activity unaffected by penicillinase. Rapidly achieved therapeutic blood levels. Proven tissue toleration.

Terramycin I.M. is the only preconstituted broad-spectrum antibiotic designed specifically for intramuscular use. Requires no refrigeration. Remains stable for at least two years. Available for immediate use in Isoject,<sup>®</sup> a disposable injection unit. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

## Terramycin<sup>®</sup> I.M. (oxytetracycline)



**Pfizer** LABORATORIES DIVISION  
New York, N. Y. 10017

**Contraindicated:** In individuals hypersensitive to any of the components of this drug.

**Warnings:** If renal impairment exists, even usual doses may lead to excessive systemic accumulation and possible liver toxicity. In such patients, lower than usual doses are indicated and for prolonged therapy oxytetracycline serum level determinations may be advisable.

Terramycin may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight. Discontinue therapy at first evidence of skin discomfort.

**Note:** With oxytetracycline, phototoxicity is not believed to occur and photoallergy is very rare.

**Precautions:** Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy.

As with all intramuscular preparations, Terramycin Intramuscular Solution should be injected well within the body of a relatively large muscle. **Adults:** The preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. **Children:** It is recommended that intramuscular injections be given preferably in the mid-lateral muscles of the thigh. In infants and small children the periphery of the upper outer quadrant of the gluteal region should be used only when necessary, such as in burn patients, in order to minimize the possibility of damage to the sciatic nerve.

The deltoid area should be used only if well developed such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Increased intracranial pressure with bulging fontanelles has been observed occasionally in infants receiving therapeutic doses of the drug, but such signs and symptoms have disappeared rapidly on cessation of treatment with no sequelae.

**Adverse Reactions:** Subcutaneous and fat-layer injection may produce mild pain and induration which may be relieved by an ice pack. Very mild gastrointestinal disturbances, not requiring discontinuance of the drug, may occur occasionally. Allergic reactions, including anaphylaxis, rarely have been observed.

**Dosage:** **Adult:** The optimal dosage varies, depending on the type and severity of infection. Unless otherwise specified, a dose of 100 mg. every 8 to 12 hours, or a single daily dose of 250 mg. should be adequate for the treatment of most mild or moderately severe infections. In severe infections, 100 mg. every 6 to 8 hours, or 250 mg. every 12 hours may be necessary.

Serum levels obtained by the recommended dosages are comparable to those provided by the oral dosage of 1 to 2 Gm. daily in adults. Antibiotic therapy should be continued for at least 24 to 48 hours after all symptoms and fever have subsided.

In certain diseases specific courses of therapy may be recommended as a general guide. In primary and secondary syphilis for example, the daily administration of 2 Gm. oxytetracycline, orally, in divided doses for two weeks has given good results. In cases of gonococcal infection two intramuscular injections of 250 mg. each, or one intramuscular injection of 250 mg. combined with one gram given orally as a single dose, will usually suffice, but repetition of this therapy will be required in an occasional case.

In the treatment of hemolytic streptococcal infections, therapy should continue for at least 10 days to prevent development of rheumatic fever or glomerulonephritis. In the treatment of staphylococcal infections indicated surgical procedures should be carried out in all cases.

**Pediatric:** A dosage of 3 mg./lb./day in two doses has been found satisfactory in the treatment of most mild to moderately severe infections. For more severe infections, higher dosages may be indicated and should be adjusted accordingly.

Terramycin Intramuscular Solution provides maximum absorption and patient toleration with minimal local irritation.

**Supply:** Terramycin (oxytetracycline) Intramuscular Solution: available in single dose, prescored glass ampules containing 100 or 250 mg. oxytetracycline/2 cc., Isoject<sup>®</sup> syringes containing 100 or 250 mg. oxytetracycline/2 cc. and 10 cc. multiple dose vials containing 50 mg. oxytetracycline/cc.

More detailed professional information available on request.



# Meeting Memos

## Oct. 22—ISMS PRESIDENT'S TOUR

*First District Meeting*  
Pheasant Run, St. Charles

## Oct. 23—New York State Action for Clean Air Committee

*5th Annual Symposium on Air Pollution and Respiratory Disease*  
N.Y. University Medical Center  
550 First Ave., N.Y.C.

## Oct. 23-25—American College of Gastroenterology

*Annual Course in Postgraduate Gastroenterology*  
Rice Hotel  
Houston, Texas

## Oct. 23-24—Illinois Hospital Association

*Annual Meeting*  
LaSalle Hotel, Chicago

## Oct. 23-25—American Academy of Clinical Toxicology

*Annual Meeting*  
Palmer House, Chicago

## Oct. 25-29—American Society of Anesthesiologists

*Annual Meeting*  
San Francisco Hilton  
San Francisco, California

## Oct. 28-Nov. 2—American Society of Clinical Hypnosis

Jack Tar Hotel  
San Francisco, California

## Oct. 29-30—American Association for the Study of Liver Diseases

Sheraton Hotel, Chicago

## Oct. 29-Nov. 2—American College of Chest Physicians

*Annual Meeting*  
Palmer House, Chicago

## Oct. 29—Frontiers of Medicine Series University of Chicago

*Special Conference*  
Center for Continuing Education  
1307 E. 60th St., Chicago  
"Community Related Health Care—  
New Patterns of Medical Practice"

## Oct. 29-31—New York University School of Medicine

*Symposium on Pharmacology of Selected Drugs Used in Dermatology: Principles of Action and Uses*  
New York University Medical Center  
550 First Ave., New York City, N.Y.

## Oct. 29-Nov. 1—Chicago Committee on Trauma American College of Surgeons

*9th Annual Course-Emergency Aid & Transportation of the Critically Ill and Injured*  
Chicago Fire Academy  
558 DeKoven St., Chicago

## Oct. 30—ISMS PRESIDENT'S TOUR

*Seventh District Meeting*  
Decatur City Club, Decatur

## Oct. 30-31—International Tissue Conference

*6th Annual Conference*  
Lankenau Hospital  
Philadelphia, Pennsylvania  
"Blood Cells as a Tissue"

## Oct. 31-Nov. 3—Association of American Medical Colleges

Netherlands Hotel  
Cincinnati, Ohio

## Nov. 2-5—Chicago Heart Association

*2nd Intl. Symposium on Atherosclerosis*  
Conrad Hilton Hotel, Chicago

## Nov. 3-5—Children's Memorial Hospital-Chicago

*Post-Graduate Course*  
Bigler Auditorium, Children's Memorial Hospital  
"Chronic Pulmonary Disease in Children and Young Adults"

## Nov. 5-8—American Society of Cytology

*Annual Meeting*  
Palmer House, Chicago

## Nov. 6—ISMS PRESIDENT'S TOUR

*9th & 10th District Meeting*  
Augustine's, Belleville

## Nov. 10-13—Southern Medical Association

*63rd Annual Meeting*  
Marriott Motor Hotel  
Atlanta, Georgia

## Nov. 10-14—American College of Preventive Medicine

Philadelphia, Pennsylvania

## Nov. 10-14—American Association of Public Health Physicians

*Annual Meeting*  
Philadelphia, Pennsylvania



**Nov. 10-14—Columbia University**

*Course in Obstetrics-Gynecology*  
New York City, New York

**Nov. 11-14—New York University  
Medical Center Dept. of  
Rehabilitation Medicine**

*Course in Clinical Electrodagnosis of  
Neuromuscular Diseases*  
Institute of Rehabilitation Medicine Research  
Pavilion  
400 East 34th St., New York City, N.Y.

**Nov. 12—Frontiers of Medicine Series  
University of Chicago**

*Depression*  
Center for Continuing Education  
1307 E. 60th St., Chicago

**Nov. 12-15—Mound Park Hospital  
Foundation, Inc.**

*Today's Hospital Problems: An Interdisciplinary  
Approach*  
Tides Hotel, Redington Beach, Florida

**Nov. 13-15—American Thyroid Association**

Drake Hotel, Chicago

**Nov. 13-14—University of Kentucky  
College of Medicine**

*Symposium*  
Albert B. Chandler Medical Center  
University of Kentucky, Lexington, Ky.  
"Recent Developments in the Surgical Care of  
Trauma"

**Nov. 13-18—American Heart Association**

Memorial Auditorium  
Dallas, Texas

**Nov. 15-19—American Association for  
Inhalation Therapy**

*15th Annual Meeting*  
Hotel Muehlebach  
Kansas City, Missouri

**Nov. 16-19—Association of Military  
Surgeons of the United  
States**

*76th Annual Meeting*  
Sheraton Park Hotel  
Washington, D.C.  
"The Medical Team"

**Nov. 17-19—Academy of Psychosomatic  
Medicine**

Shadows Hotel  
Scottsdale, Arizona

**Nov. 17-21—New York University  
Medical School**

*Postgraduate Course*  
New York University Medical School  
550 First Ave., New York City, N.Y.  
"Correlative Neuroradiology"

**Nov. 19-20—The Cleveland Clinic Educational Foundation**

*Postgraduate Course*  
The Cleveland Clinic  
2020 East 93rd St., Cleveland, Ohio  
"Neurosurgical Technics"

**Nov. 19-22—National Easter Seal Society For Crippled Children & Adults**

*Annual Convention*  
Sheraton-Columbus  
Columbus, Ohio

**Nov. 20—National Society for the Prevention of Blindness**

Roosevelt Hotel  
New York City, N.Y.

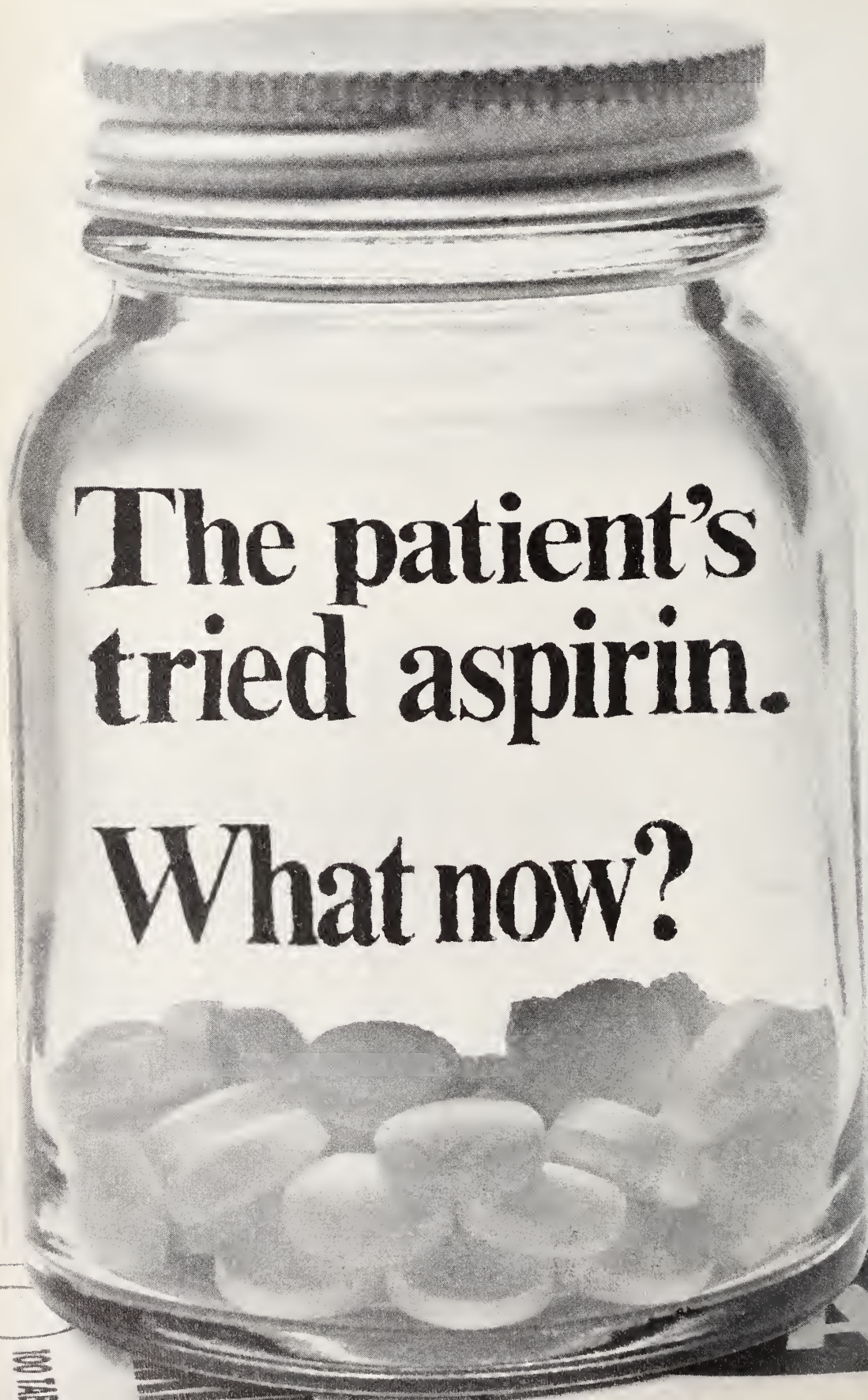
**Nov. 21-22—Institute of Medicine of  
Chicago**

*Workshop*  
Ambassador Hotel, Chicago  
"The Delivery of Medical Care in the 1970's"

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**Hire the Handicapped**

"The handicapped worker has not only shown himself to be a good and competent employee; he frequently brings something extra in the way of motivation. He tries harder because he wants to show what he can do. As a result, employment of the handicapped is no longer regarded as an act of compassion; it is a matter of good business judgment"—Thomas J. Watson, Jr., Chairman of the Board, IBM Corp.



**The patient's  
tried aspirin.**

**What now?**



There's a good chance your patient needs more than a non-prescription analgesic for pain relief. Especially after self-medication has failed.

Because continuing, increased pain and discomfort may in part be a reflection of anxiety, Equagesic is worthy of consideration. In a single, non-narcotic preparation, it helps relieve pain . . . and associated anxiety and tension.

## Tablets

# Equagesic<sup>®</sup>

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

### IN BRIEF

**Contraindications:** History of sensitivity or severe intolerance to aspirin, meprobamate or ethoheptazine citrate.

**Warnings:** USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

**Precautions:** Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could

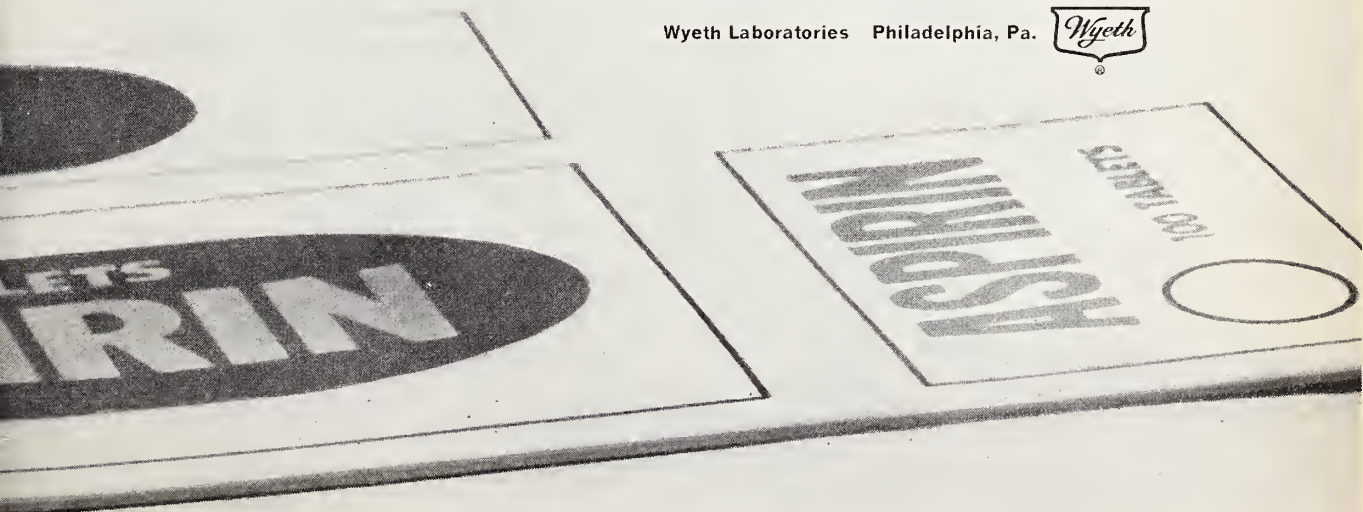
be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

**Adverse Reactions:** Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

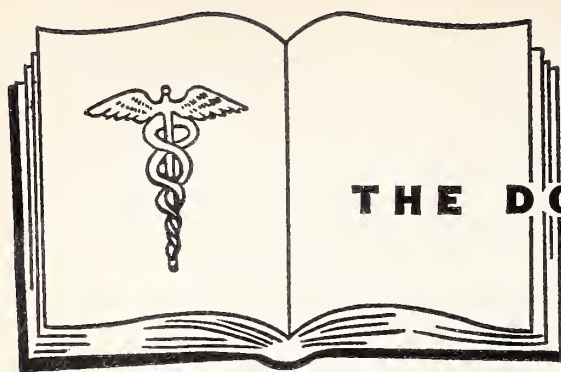
**Overdosage:** See precautions section for management of overdosage.

**Composition:** 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.







## THE DOCTOR'S LIBRARY

**ORTHOPEDIC DISEASES: PHYSIOLOGY, PATHOLOGY, RADIOLOGY.** Ernest Aegerter, M.D., John A. Kirkpatrick, Jr., M.D., W. B. Saunders Co., Philadelphia, London, Toronto, 1968, 890 pages.

The standard version of the Bible of orthopedic diseases is now available in its third edition. Past editions of this book have been the primary text on skeletal diseases for orthopedic residents throughout the country. It is also a prime reference work for all clinicians encountering orthopedic diseases, including the orthopedic surgeon, the radiologist and pathologist. This revision was made necessary by the recent major advances in the fields of bone morphology and physiology.

Several important additions and changes have been made in the text to update and improve it. The new edition is divided into five sections. The first section includes the general consideration of connective tissue with review of the basic components of connective tissue. Section two deals with disturbances in skeletal development. One of the fundamental problems confronting authors who write about, and clinicians who deal with and treat, skeletal dysplasias has been the almost total disorganization in their classification. Chapter six is the authors' attempt at organization of this confusing array of diseases. This is a significant departure from the second edition, and seems to be an improvement. Section three deals with disturbances in the normally-formed skeleton, and includes repair of fractures, infectious diseases, metabolic diseases and diseases due to endocrine dysfunction. Section four includes tumors and tumor-like processes. It is interesting to note that the authors have finally included a section on giant-cell tumors, which they discuss under the heading of "Osteoclastoma." They discuss at some

length the evolution of thinking regarding this tumor, and present their ideas of its characteristics. Section five includes diseases of joints, muscles and soft-part tumors. This includes a section on arthritis and an excellent chapter on diseases of skeletal muscle, which is a new addition. This 40-page section of the book is as concise a summary of the myopathies as there is available anywhere.

This edition of an already-excellent work may be recommended to every clinician dealing with patients manifesting skeletal diseases. Because of the significant changes and additions that have been made, clinicians possessing prior editions are encouraged to consider adding this new book to their library.

David C. Bachman, M.D.

**INTERNAL MEDICINE BASED ON MECHANISMS OF DISEASE**, Edited by Peter J. Talso, M.D. and Alexander P. Remenchik, M.D. 1968. C. V. Mosby Co., St. Louis. pp. 797, illus., \$17.50.

As Illinois physicians, our pride in the new textbook, *INTERNAL MEDICINE BASED ON MECHANISMS OF DISEASE* might be provincially pardonable because the authors are our friends; their skillful and dedicated medical care is evident in our own community; and the performance of their students has demonstrated the quality of their teaching. However, outside of our own little circle, our pride can grow still more, fully justified because our friends have written an entirely new book that halts the disturbing recent trend for textbooks of medicine to grow ever bigger and less manageable.

The first 200 pages consider mechanisms responsible for production of disease: genetic factors, atherosclerosis, aging, interactions with infectious material, host defense,

neoplasia, chemical and physical injuries, deficiency of specific nutrients, iatrogenic and factitious factors, and psychological disturbances. The rest of the book deals with specific diseases likely to be encountered by the young physician along with a few unusual diseases that serve to illustrate basic mechanisms of disease. Perhaps if the connection between the discussion of mechanisms and the specific disease entities, chosen for presentation, might have been closer, and if the perspective of mechanisms extended further, the book would have been even better. Some parts could have been even further shortened by editing out long qualifying clauses likely to be lost on the student grasping for fundamentals.

The book is well put together, easy to handle and easy to read. Illustrations are somewhat sparse but well chosen and readily understood. Reference lists are short, appropriate, and selected for the most part from publications of the last decade. The specialist can find more information elsewhere when he seeks details about rare and unusual diseases. The practicing physician can profit by its broad base for modernizing his view of the entire field of internal medicine but will find few of the answers to questions generated in his daily practice that send him scurrying to the books for quick answers. But the book is designed for medical students. They will find a broad fundamental approach suitable for

beginning to deal with sick people. They will be able to find time to read all of this fine new textbook.

William H. Wehrmacher, M.D.

**HANDBOOK OF NON-PRESCRIPTION DRUGS.** 1969 Edition. George B. Griffenhagen, editor. Published by American Pharmaceutical Association, Washington, D.C., 160 pages., illus. \$5.00.

This interesting book contains 29 chapters, each devoted to a specific class of home remedies. Formulas for more than 800 different brand name products are included. Each chapter is co-authored by qualified pharmaceutical experts in teaching and in active practice throughout the country. There are 600 separate references.

The hard cover volume contains seven new chapters and represents a 50% enlargement in content and size. Newcomers to this edition include vitamins, menstrual aids, ophthalmic products, astringents, mouthwashes, antiseptics, oral hygiene aids, and hair preparations. The Handbook should prove interesting to the physician and especially to the pharmacist who may be able to expand his knowledge for the need and the usefulness of over-the-counter products.

T. R. Van Dellen, M.D.

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### **Speed Kills**

While more than 40 per cent of driver-error-caused deaths on America's highways in 1968 were blamed on excessive speed, only 20 per cent of the injuries were attributed to this activity. The second major cause of fatalities blamed on actions of drivers was reckless driving. It figured in nearly 15 per cent of the deaths and more than 39 per cent of the injuries.

The conclusion, voiced many times before, according to a spokesman for The Travelers Insurance Companies, is "speed kills."

Other major factors involving actions of drivers resulting in deaths and injuries include driving on the wrong side of the road, not having the right-of-way, and driving off the roadway.

In the ten year period from 1959 through 1968, young driver involvement in fatal accidents increased more than 20 per cent. Last year, precisely one-third of people at the wheel when accidental death occurred in car crashes were 25 years or younger. The implication of immaturity expressed by speed is inescapable, said The Travelers spokesman, "under-25 drivers amount to only one-fifth of the driver total but they are in the terrible middle of one-third of all fatal auto crashes."

The 1968 traffic death toll reached 55,300, 3,000 more than were killed in 1967. Injuries in 1968 rose to 4,400,000 from 4,200,000 in 1967.

**COOK COUNTY**  
**Graduate School of Medicine**  
**CONTINUING EDUCATION COURSES**  
**STARTING DATES—1969**

SPECIALTY REVIEW COURSE IN SURGERY, Part I, October 20  
 SPECIALTY REVIEW COURSE IN OB-GYN, November 3  
 SPECIALTY REVIEW COURSE IN MEDICINE, Part II, Nov. 10  
 SPECIALTY REVIEW COURSE IN PEDIATRICS, November 10  
 SPECIALTY REVIEW COURSE IN ORTHOPEDICS, Nov. 17 & Dec. 8

PATHOLOGY REVIEW COURSES FOR SPECIALTIES, Request Dates

SURGERY OF COLON & RECTUM, One Week, October 13  
 MANAGEMENT OF COMMON FRACTURES, One Week, Oct. 13  
 BLOOD VESSEL SURGERY, One Week, November 10  
 BASIC OBSTETRICS, One Week, October 20  
 BASIC GYNECOLOGY, One Week, October 27  
 INTERMEDIATE CARDIOLOGY, One Week, October 20  
 GENERAL PRACTICE REVIEW, One Week, November 3  
 MANAGEMENT OF PEDIATRIC HEART DISEASE, 3 Days, Oct. 15

GENERAL PEDIATRICS, One Week, December 1  
 ADVANCES IN MEDICINE, One Week, December 1  
 RADIOISOTOPES, One or Two Weeks, Request Dates

*Information concerning numerous other continuation courses available upon request.*

**TEACHING FACULTY**  
 Attending Staff of  
 Cook County Hospital

Address:  
 REGISTRAR, 707 South Wood Street,  
 Chicago, Illinois 60612

**NEW**  
**PHARMACEUTICAL**  
**SPECIALTIES**

by Paul deHaen

For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturer's package insert or brochure.

**Single Chemicals:** Drugs not previously known, including new salts.

**Duplicate Single Products:** Drugs marketed by more than one manufacturer.

**Combination Products:** Drugs consisting of two or more active ingredients.

**New Dosage Forms:** Of a previously introduced product.

**A New Drug Application** has been granted by the U.S. Food and Drug Administration for the following new drugs, but their marketing date has not been announced.

**MATULANE** For the palliative treatment of Hodgkin's disease

**Nonproprietary Name:** Procarbazine hydrochloride

**Manufacturer:** Roche Laboratories

**ARISTOSPAN** Corticoid anti-inflammatory agent with prolonged local action

**Nonproprietary Name:** Triamcinolone Hexacetonide

**Manufacturer:** Lederle Laboratories

**The following new drug has been marketed:**

**DUPLICATE PRODUCT**

**RESPIRE** Mucolytic agent

**Manufacturer:** Bristol Laboratories

**Nonproprietary Name:** Acetylcysteine

**Indications:** Adjuvant therapy in respiratory diseases associated with abnormal, viscid, or inspissated mucous secretions.

**Contraindications:** Hypersensitivity to the drug. Open Airways must be maintained.

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**Supplied:** Solution—10% and 20%, plastic stoppered glass vials.

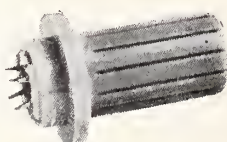
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## *Clinics for Crippled Children Scheduled*

Twenty-six clinics for Illinois' physically handicapped children have been scheduled for November by the University of Illinois, Division of Services for Crippled Children. The Division will conduct twenty-one general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing service. There will be three special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- Nov. 4—Alton, General—Alton Memorial Hospital
- Nov. 4—Pittsfield—Illini Community Hospital
- Nov. 5—Hinsdale—Hinsdale Sanitarium
- Nov. 5—Fairfield—Fairfield Memorial Hospital
- Nov. 6—Du Quoin—Marshall-Browning Hospital
- Nov. 6—Peoria, Cerebral Palsy (A.M.)—St. Francis Community Clinic Area
- Nov. 6—Sterling—Community General Hospital
- Nov. 11—East St. Louis—Christian Welfare Hospital
- Nov. 11—Peoria, General—Children's Hospital
- Nov. 12—Joliet—St. Joseph's Hospital
- Nov. 12—Champaign-Urbana — McKinley Hospital
- Nov. 13—Springfield, General—St. John's Hospital
- Nov. 13—Macomb — McDonough District Hospital

In addition to being eligible for education, loan and other VA benefits, veterans of the Korean Conflict, Post-Korean Period and Viet-Nam Era may be eligible for other benefits not handled by the Veterans Administration. These include; unemployment pay, reemployment rights, and job finding help handled by the Department of Labor, U. S. Employment Service and State employment offices.

- Nov. 13—Effingham, General—St. Anthony Memorial Hospital
- Nov. 14—Chicago Heights, Cardiac—St. James Hospital
- Nov. 19—Evergreen Park—Little Company of Mary Hospital
- Nov. 19—Centralia—St. Mary's Hospital
- Nov. 19—Springfield, Cerebral Palsy—Diocesan Center
- Nov. 20—Elmhurst, Cardiac—Memorial Hospital of DuPage County
- Nov. 20—Decatur—Decatur Memorial Hospital
- Nov. 21—Chicago Heights, Cardiac—St. James Hospital
- Nov. 25—East St. Louis—Christian Welfare Hospital
- Nov. 25—Danville—Lake View Hospital
- Nov. 25—Peoria, General—Children's Hospital
- Nov. 26—Elgin—Sherman Hospital
- Nov. 26—Rockford—St. Anthony Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

A unique center at the University of Illinois Medical Center Campus Chicago, coordinates the treatment of children and adults hampered by a wide range of agonizing congenital and acquired malformations of the face. Called the "Center for Craniofacial Anomalies," the center provides education, research and public service, and is financed by a \$280,000 federal grant.

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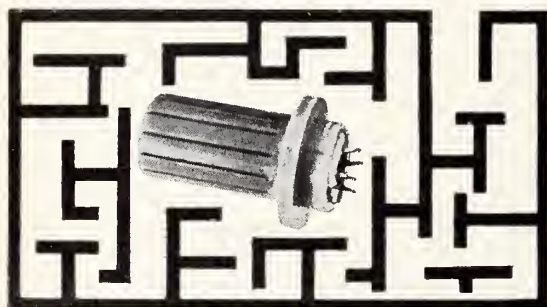
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## Obituaries

\***Gerald C. Ackerman**, Norridge, died July 29 at the age of 30. He graduated in 1964 from Loyola's Stritch School of Medicine.

**Eugene L. Acuff**, Rock Island, died August 12 at the age of 34. He served as medical director for Strassenburgh Pharmaceuticals of Rochester, N.Y.

\***Herman J. Adelman**, Joliet, died August 11 at the age of 85. He was a member of the ISMS Fifty-Year Club.

\***Carroll L. Birch**, Chicago, died July 7 at the age of 71. She was a researcher and faculty member of the University of Illinois Medical Center. In 1952 she was named "Medical Woman of the Year" by the Medical Women's Association.

\***Adolph A. Bona, Sr.**, Chicago, died August 9 at the age of 71. He was a former member of the Chicago Board of Health.

\***John P. Burgess**, Rock Island, died July 21 at the age of 68. He was past-president of the Rock Island County Medical Society.

**Joseph E. Campbell**, Chicago, died August 23 at the age of 44. He was chief pathologist for the Cook county coroner's office in 1960.

\***Russell G. Iseberg**, Chicago, died September 7 at the age of 61. He was past president of the Belmont Community Hospital staff.

\***Katherine Kalnins**, Carbondale, died August 31 at the age of 50. She was a physician at the Southern Illinois University Health Center.

\***Roy Kegerreis**, Elmhurst, died August 18 at the age of 83. He was chairman of the DuPage County Tuberculosis Board for 12 years.

\***Lowell C. Nevelin**, Galesburg, died August 4 at the age of 59. He was on the staff of the Galesburg State Research Hospital.

\***Johannes F. Ort**, Robinson, died July 31 at the age of 67.

**Arthur P. Picard**, Chicago, died September 2 at the age of 72.

\***John J. Zavertnik**, Chicago, died August 18 at the age of 72. He was former Chief of Staff at St. Anthony de Padua hospital.

\*Indicates Member of Illinois State Medical Society.



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## Cancer Prevention Study

The American Cancer Society, in issuing the final report on its six-year epidemiological research project known as the Cancer Prevention Study, commends the assistance it received from Illinois physicians who responded to the Society's request for information on 1,539 persons whose death certificates gave cancer as cause of death.

This nationwide effort, aimed at finding out why some persons are more likely to develop cancer than others, has now entered a critical new phase, where results will be tallied and analyzed for valuable leads. Some 68,000 volunteer researchers, including 5,000 in Illinois, enrolled 1,079,000 men and women, 80,651 in Illinois, over the age of 30. Each subject filled out a detailed questionnaire including family history, physical complaints data and other factors.

Once a year, for six years, they were traced (alive or dead), and every other year, each living subject was asked to fill out a questionnaire giving additional information on hospitalization, air pollution factors and changes in smoking habits.

The persistent detective work of Illinois volunteers involved in following up the subjects in Illinois earned national recognition. Only .6 of 1% or 452 of the 80,651 subjects were lost.

Of the 79,218 interviewed and followed through the six-year period, 72,832 (91.9%) were traced. 5,943 (7.5%) died. Of these, the death certificates of 1,539 (25.9%) gave cancer as the cause. Questionnaires requesting further clinical information went to physicians who had signed these death certificates. 1,521 (98.8%) of these questionnaires were returned.

The Cancer Prevention Survey continues to yield valuable clues as information is recorded on sophisticated IBM processing and analyzed by leading scientists on the subject. Among the valuable yield of information to date is the study of smoking in relation to death rates in women as well as men. Currently under study is the attempt to identify groups with the high risk of developing cancer and factors involved in such risks. The major findings must be a result of painstaking and exhaustive study, based on many factors, which will constitute a series of reports over a period of years.

# BLUE SHIELD REPORT



## FOR *Illinois Physicians*

PUBLISHED MONTHLY BY: BLUE SHIELD PLAN OF ILLINOIS MEDICAL SERVICE • 222 NORTH DEARBORN ST. • CHICAGO, ILLINOIS 60601

Vol. 3, No. 11

November, 1969

### Utilization Review

Suggested guidelines have been proposed by the National Association of Blue Shield Plans to assist medical societies in peer review.

The concept includes the review of what might be considered unusual medical practices or charges by the local county medical society peer review committees and a review of medical claims processed by Blue Shield Plans.

The suggested guidelines are being referred to the State Medical Society in order to provide a pattern for review that will be consistent with the way medicine is practiced in the State of Illinois. The guidelines provide for:

1. Supplying data for the information of physicians serving on utilization review committees. The information that can be made available will be developed to provide physicians who receive services paid for by Blue Shield and Blue Cross as well as Medicare.

2. A routine scanning process will be undertaken in order to refer what may appear to be unusual practices by physicians through the local county medical society.

Statistical reports will be made available through appropriate committees of the medical society when necessary in order to assist it in arriving at a recommendation to the third party payer.

3. Routine claims review will be undertaken by professional personnel of Illinois Blue Shield and questionable claims will be referred to the appropriate county medical society.

Blue Shield, in 1967, committed itself to the House of Delegates of the Illinois State Medical Society to refer cases involving disputes between physicians and the Blue Shield Plan to the appropriate county medical society for review with the understanding that the decision could be appealed to the district or state medical society committee either by the physician or by Blue Shield. Blue Shield agreed to accept decision by the final review committee.

In view of the position taken by other public and private agencies regarding the services of physicians, the Blue Shield Plan of Illinois Medical Service is offering its assistance to the profession by providing a working base which the state society can use in arriving at a decision regarding peer review, long accepted by the medical profession.

### Developing Depth of Payment, Broader Scope of Coverage

Several years ago Blue Shield initiated an intensive program to develop a more equitable method of paying physicians for their services based on "Usual, Customary" charges.

In October of 1968, at a special conference of Blue Shield Plans, a new membership standard was adopted calling for all Plans to be in a position to offer such coverage.

This action converted the National Association of Blue Shield Plans into a truly nationwide network capable of offering the same benefits everywhere.

Programs based on physicians' "Usual, Customary" charges are now commonplace among Blue Shield Plans.

One year ago, 56 Plans were underwriting such programs with an enrollment of nearly six million persons. Now, in contrast, virtually all Plans are underwriting, or are nearing implementation of such a program and the estimated total enrollment exclusive of Medicare is 13 million persons.

Broader scopes of coverage, including office and home care, diagnostic coverage, prescription drugs, and dental care are also being made available by Plans, reflecting consumer demand for an ever broadening program of comprehensive benefits.

1969 is the year the prescription drug program goes into effect in one of Blue Shield's largest groups, the auto industry.

And prepaid dental care, which thus far has had exposure primarily in the western states, is growing in popularity in other areas of the country.

Many Plans are currently offering coverage for home and office calls while others are in the process of developing such coverage, and most Plans offer coverage for diagnostic examinations.

One of the major impacts of Medicare has been its creation of a shift from the traditional concept of in-hospital care to other types of services in the home or the physician's office.

Because of this trend, coverage for diagnostic examinations in the home and office is expected to expand even more.

Through these efforts, Blue Shield continues to reflect the fact that America's good health is our greatest concern.



## ASK BLUE SHIELD

### • • • ABOUT MEDICARE

#### Physical Therapy

Physical therapy is covered by the Medicare program under the following circumstances:

- A) when performed under the supervision of a qualified physical therapist;
- B) is rendered according to the *written* orders of a physician;
- C) it is of a "restorative" nature rather than "maintenance";
- D) the services are rendered at an approved clinic, rehabilitation agency, participating hospital, participating Extended Care Facility or by an approved Home Health Agency.

To elaborate on the above, physical therapy must be directly related to the patient's course of treatment which is prescribed by the physician to restore the patient's level of physical ability which was lost due to a recent illness or injury. The physician is responsible for determining the need for therapy, the capacity and tolerance of the patient, and the anticipated goals as well as for frequently evaluating the physical therapy program to determine if the patient continues to need "restorative" therapy. Not covered is maintenance or supportive therapy which is given to patients to prevent further deterioration. These patients may have chronic conditions or may be enfeebled due to senility. A relatively unskilled person rather than a physical therapist would be able to supply the necessary services to this type of patient. Therapy which is intended for palliation only or to prevent further deterioration is not a covered service under the Medicare program.

The Medicare law was amended July 1, 1968, to cover *out-patient* physical therapy at approved clinics, rehabilitation agencies and public health agencies.

However, reimbursement can be made only when provided in accordance with the following regulations (in addition to the conditions mentioned above):

- A) The physical therapy was required on an out-patient basis.
- B) The plan of treatment was established and signed by the physician.
- C) The signed orders of the physician are filed with the clinic's permanent record for the patient.
- D) The therapy services were rendered while the patient was under the physician's care.

It is the physician's responsibility to recertify in writing at least every 20 days that there is need for therapy services and he should estimate how long the services will be required. The recertification must be signed by the physician who established and reviewed the plan of treatment. Even though it is usually not necessary for the clinic to send the certification to the Medicare carrier for review, the clinic must verify on the billing form that certification is on file in their office.

#### Preventing An Incorrect Split Payment

On the S.S.A. 1490 "Request for Payment" Form, there is a box requesting "amount paid". The only amount which should be indicated in this area is that portion of the bill which the patient has paid. This area should never show reimbursement received from Blue Shield or any other insuring agency. Indicating a payment other than that received from the patient could result in the Medicare reimbursement being incorrectly "split" between the physician and the patient.

#### Part B \$50.00 Deductible Carry-Over

Any expenses incurred during the months of October, November, or December which have been credited toward the patient's \$50.00 deductible, can also be used to meet the deductible for the following year.

Thus, if Mr. X's covered Medicare expenses prior to October 1969 total \$10.00 and another \$30.00 is incurred during the last three months of the year, the \$30.00 will be credited to the 1969 as well as 1970 deductible.

The deductible "carry-over" ruling helps patients who might otherwise meet their \$50.00 deductible twice within a short period of time.

#### Time Limitations For Filing Claims

Time limitations for filing Medicare Part B claims were established by the 1967 Social Security Amendments.

All claims for services rendered October 1, 1967, through September 30, 1968, must be filed no later than December 31, 1969. These claims must be filed with the Medicare carrier (Blue Shield for the counties of Cook, Kane, Lake, Will and DuPage).

Claims for services rendered prior to October 1 of one year must be filed by December 31 of the following year. However, services and supplies provided during the last three months of any calendar year are considered to have been provided in the following year.

We suggest that claims for services October 1, 1967, through September 30, 1968, be submitted for payment to the Medicare office as soon as possible. The cut-off date is drawing near.



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**Warning:** May be habit forming.

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## ON THE COVER

This month's cover depicts a portion of the *Illinois Medical Journal* sponsored Membership Opinion Survey. The survey, the second conducted in this fashion in as many years, received replies from some 38% of the membership. This allows a good expression of the membership opinion to the officers of ISMS and indicates the direction which should be followed in many instances.

The results of this year's survey will be chronicled in the pages of *IMJ* over a three-month period, November through January. Your attention is directed to page 573 of this issue for the first installment.

---

### University of Chicago Receives Ford Grant

The Ford Foundation has awarded a \$418,770 grant to the University of Chicago for research that may lead to the development of immunological means of controlling implantation by inactivating the protein in the uterine cell that attracts estrogen.

The grant will allow Professor Elwood V. Jensen, a molecular biologist who is director of the Ben May Laboratory for Cancer Research, to undertake studies that will be of interest to both reproductive biologists and cancer specialists.

Dr. Jensen's previous research has shown that estrogen, which is necessary for the growth of certain types of cells in the uterus, enters the cell and is attracted to a protein there called the "uptake receptor." If these receptors could be inactivated, uterine cellular growth would be inhibited and the uterine changes necessary for implantation and development of the fertilized egg would be prevented.

It is theoretically possible that these uptake receptors could be controlled by immunological means. But before an antigen can be developed for this purpose, the receptors must be isolated so that their chemical, physical, and immunological properties can be identified. Dr. Jensen's research will seek to isolate uptake receptors and study their characteristics.

Since cancer cells in the uterus may proliferate in a similar manner, the control of uptake receptors is also of interest to cancer specialists.

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**Precautions:** There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

**Adverse Reactions:** *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.







Edward W. Cannady, M.D.

# The President's Page

## We Need Adequate Public Health Protection

Twenty two percent of Illinois' population—2,050,000 people living in 45 counties—are being deprived of adequate public health protection.

These people don't have such commonly accepted advantages as school immunization programs; protection against unfit drinking water from contaminated wells; public eating places that are regularly checked for cleanliness; and control of water and air pollution.

In these counties, there are children drinking milk that is not adequately protected from contamination. . . . there are families using antiquated sanitation facilities that could poison their water supply. . . . and there are pregnant women who don't even know the fundamentals of prenatal care. . . . and won't see a doctor until they enter the hospital to deliver.

**—These people are being cheated because there is no public health department in their area.**

Do the residents in these counties suffer more contagious disease, have more untreated chronic illnesses, and a higher infant mortality than their more fortunate neighbors who enjoy the benefits of a full-time health department? Unfortunately such statistics from these counties are not available. . . . again, because no health department exists to compile them.

Thus far, I have spoken of those counties where no health department exists. I'm also told by the Illinois Department of Public Health that the state has 25 counties with only limited health department services. These counties have a combined population of nearly one million persons—or approximately 10% of the state's total inhabitants.

***In other words, about one-third of our state does not enjoy the many advantages supplied by a county or multi-county health department facility.***

As physicians, we should be particularly aware of the many services a full-time health department can provide. Such vitally important health safeguards as inspection of drinking water, inspection of food processing and serving, contagious disease immunizations and detection, regulations to insure proper waste disposal, educating expectant mothers in proper prenatal care, are just a few. A full-time health department makes our jobs easier in all these ways.

I like to think that physicians are leaders in their communities. Their judgment usually carries considerable weight with local officials.

I therefore ask ISMS members to look at the map accompanying this message. If a full-time public health department does not exist in your county, take the lead in marshalling public opinion. . . . to place this matter before the voters. Your State Medical Society's House of Delegates has given its complete backing to the public health department concept. Last May the House unanimously declared that "public health departments should be established where none now exist and that county medical societies should give their whole-hearted support."

How much will an adequate public health program cost? Not much by today's taxing standards. County health departments are supported by taxes, and the annual tax levy is prohibited by law from exceeding \$1 per \$1,000 assessed valuation.

*(Continued on page 632)*

# Perforation of the Caecum

By

## Blunt Abdominal Trauma

BY JOHN G. RAFFENSPERGER, M.D. AND GABRIEL ANGRESS, M.D./CHICAGO

*In 1966 automobile injuries accounted for more than one third of the accidental deaths in children up to 14 years of age. Until we can prevent this senseless loss of life, physicians must concentrate upon the proper management of children who are the targets of an automobile. Trauma to the head and abdomen cause most of the potentially lethal injuries. In each of these anatomical areas, prompt, accurate diagnosis, skillful surgical care and meticulous post-operative support are essential to survival. Many times, the signs and symptoms of intra-abdominal injury are subtle, and considerable time may be spent in arriving at the decision to operate. On the other hand, some children are obviously severely injured and demand emergency resuscitation.*

*The following case history illustrates the steps taken to prevent one severely injured child from becoming another "statistic."*

---

John G. Raffensperger, M.D., is chief, pediatric surgery, Cook County Children's Hospital and associate professor of surgery, University of Illinois. Gabriel Angress, M.D., is a resident in urology at Cook County Hospital.

### Case Report

R.R. is a four-year-old boy who was struck by an automobile which pinned him against the bumper of another car. The police at first took him to a nearby hospital, where superficial wounds of his flank were dressed. He was unconscious for about an hour, but was given no further treatment prior to his transfer to the County Children's Hospital, 5 hours later. On admission he was restless but could respond to questions. He was in severe shock, with an unobtainable blood pressure, a pulse of 160 per minute and a respiratory rate of 30. His abdomen was flat, tender and rigid. His peristaltic sounds were hypoactive. The remainder of the physical examination was normal. He vomited clear yellow fluid twice during the examination. The resident who first examined the boy immediately drew a blood sample for type and cross match and started an intravenous infusion of lactated Ringers solution. He also inserted a nasogastric tube and a foley catheter. There was no urine in the child's bladder and none was excreted prior to his operation.

Further therapy consisted of a venous cut-down and the administration of whole

blood as soon as it became available. After the child had received 500 ml. of the lactated Ringers solution and approximately 300 ml. of blood his pulse slowed to 130 and his blood pressure rose to 60/40. He was operated upon an hour after his admission to the Children's Hospital and six hours after his injury. There was 700 ml. of bloody fluid in his peritoneal cavity with fecal contamination from two actively bleeding lacerations in the lateral wall of the caecum. There were no other injuries. Because of the fecal contamination and the child's general poor condition, the surgeon elected to exteriorize the injured caecum rather than to resect and anastomose the intestine.

In the immediate post-operative period, his blood pressure rose to 90/70 and his pulse was 120; however, his skin was cool and cyanotic and his respirations were depressed. His arterial oxygen saturation fell to 80%, though he was in an oxygen tent. Consequently, the endotracheal tube was reinserted and his respirations supported with a Bennet Respirator. He continued to be treated with intravenous fluids, plasma, and large doses of antibiotics. He commenced secreting urine during the operation, and his out-put averaged 25 ml. per hour during the ensuing days. The day following operation, the endotracheal tube was removed and he was again given oxygen. His respirations became shallow, and his arterial blood gas studies indicated increasing respiratory acidosis. Consequently, he was returned to the operating room, a tracheostomy was performed, and his respirations were assisted with a Bennet Respirator.

Three days after the operation, he was stable, alert and commenced to pass liquid intestinal contents from the ileostomy. At this time, a ten square centimeter area of necrotic skin was debrided from his right flank. He gradually improved, and was weaned from the respirator by the sixth post-operative day. Unfortunately, his abdominal incision became infected and he eviscerated two days later. After wound closure he continued to improve, tolerated a soft diet and the ileal drainage became semisolid. His abdominal wounds were slow to heal and at various times *E. coli*, *Staphylococcus aureus* and *Aerobacter aerogenes* were cultured. A split thickness skin

graft was required to close the flank wound. Two months after his original injury, the ileostomy was closed and he was discharged from the hospital several days later.

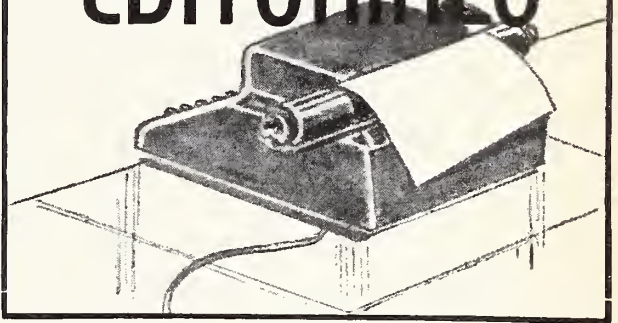
### Discussion

This boy nearly died during three distinct periods after his injury. Because of the delay in therapy he was near death from shock and fluid loss on admission to this hospital. The physician who admitted him to the Surgical Service rapidly resuscitated him with lactated Ringers solution and whole blood. His initial treatment was guided by the boy's vital signs and his central venous pressure. In the immediate post-operative period frequent determinations of his arterial blood gases and pH led to the diagnosis of respiratory depression. The prompt use of ventilatory assistance and a tracheotomy prevented his death from hypoxia and respiratory acidosis. Finally, he could have succumbed to the combined effects of malnutrition and infection. Antibiotic therapy at this stage was guided by frequent wound cultures. His nutrition was supported by plasma and whole blood transfusions, and with intravenous 5% amino acids with 15% dextrose. Mortality from an abdominal injury is directly related to the length of time from the injury to operation.<sup>1-2</sup> Vannix and Carter found that only 7 of 138 colon injuries were caused by blunt trauma.<sup>3</sup> At the Boston Children's Hospital,<sup>4</sup> there were 2 colon perforations in 74 children with blunt abdominal trauma. During the past five years, we have operated upon 70 children for abdominal injuries, and this is the only child with a colon perforation secondary to blunt trauma. The small intestine is frequently lacerated when it is caught between force applied to the abdominal wall and the vertebra. In our patient, the most likely etiology was acute compression which burst the intestine like a paper bag. When operated upon early, lacerations of the colon may be resected and a one stage anastomosis performed. However, in the face of fecal contamination it is preferable to exteriorize the injured bowel.<sup>5</sup>

*(Continued on page 636)*



# EDITORIALS



## **WE NEED BETTER AMBULANCES**

The child described on page 565 was struck by an auto 14 blocks from the Cook County Hospital, in Chicago. He was first taken to a nearby hospital, but was not treated there. Instead, he was transferred to the Cook County Children's Hospital nearly five hours after his injury. This boy survived because of care by surgical residents, interns, anesthesiologists, staff surgeons and countless nurses. During his first two days in the hospital, the anesthesia staff performed 20 arterial blood gas determinations. Thirty sets of serum electrolyte determinations were done during his first 12 days after injury. This case demonstrated that a large well trained staff and 24-hour laboratory service is re-

quired to provide optimum care for trauma victims.

Police vehicles continually bring terrified injured children with unsplinted fractures, neglected open wounds and major visceral trauma to our doors. Most have detoured through another hospital emergency room. This is not the fault of the hospitals, but rather of the archaic police ambulance system which operates under outdated rules and city ordinances.

It is time for physicians to work for improved transportation of accident victims to hospitals which are equipped for and are vitally interested in their care.

JGR

## **WE NEED MORE GPs**

State medical societies are doing their best to encourage more students to become family physicians. This is understandable, because there is a shortage of GPs in rural and suburban areas, in small towns, and in the ghettos of large cities. Many plans have been suggested including the establishment of departments of general practice in teaching centers or assigning senior students to general practitioners on a clerkship basis.

Medical faculties are accused of discouraging students from going into general practice. The same has been said of physicians on the staff of university hospitals. This is a reasonable accusation because there is a manpower shortage and those in large medical centers have the

first crack at selling seniors and interns on their particular specialty. Many of these fledglings never get the chance to see the other side of the coin.

Hickman<sup>1</sup> made a wise suggestion on how to get plenty of GPs . . . and fast. His plan is to limit the availability of specialty training programs. There are roughly 40,000 approved residency openings in the United States. The average residency program is 4 years in duration, which means that approximately 10,000 first-year positions are available. All of these could be filled by the 8,000 medical students who graduate annually.

By decreasing the number of approved residency openings to 10,000 or 12,000, more graduates would be forced into gen-

eral practice. Furthermore, the keen competition for residencies would considerably improve the caliber of the specialist and the GP. The program could be initiated by the AMA thru its Council on Medical Education. There is no doubt, however, that such a proposal will draw criticism from many quarters, except the patient.

Group practice is an alternate plan in which each member limits himself to a specialty. The clinic, in covering all phases of medicine, will, in reality, provide the community with a general practice.

Neighborhood health centers are advocated by the government, mainly to meet the needs of the poor. To the best of my knowledge, they are staffed by physicians

including specialists and GPs. Should our government assume a greater control over the field of medicine, we may be forced to turn to this type of practice on an expanded scale. In all probability, it will take us back to wartime. The health centers will be dispensaries where ambulatory care and prophylaxis are rendered. Specialists will teach and provide care for the hospitalized. And—the rift between the GP and specialist will grow wider.

T. R. Van Dellen, M.D.

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## WHERE WILL IT ALL END?

In Michigan, an appellate tribunal reversed a lower court which prohibited the plaintiff from using the defendant doctor as an expert witness **against** himself. The court said that, "a civil defendant has no protection against subjecting himself to liability. If his testimony will provide facts which will aid the court in arriving at a just decision, he has the duty to testify. Any loss to the sporting aspect of the adversary proceedings would be outweighed by the benefit to the judicial system." The courts therefore make quite a distinction between a murderer or rapist and a physician on trial for malpractice. The criminal is prohibited from testifying against himself.

The time-worn and flimsy excuse for liberalizing rules of evidence and new methods for proving malpractice is the "conspiracy of silence." This seems to mean that if a physician reviews the evidence and doesn't find a departure from the standard of care and cannot therefore testify that malpractice existed, he is a "conspirator" against the patient who is praying for an award. It simply is not true that every law suit against a doctor resulted from malpractice. If a physician has done nothing wrong, why should the plaintiff's attorneys become so irate because other physicians refuse to testify that he has?

There has been no dearth of suits against doctors in recent years, and every case

has produced physicians who testified in behalf of the plaintiff. Where is the conspiracy of silence?

The "locality rule" has virtually been eliminated by the courts. In the past, the plaintiff had to establish that the defendant physician departed from the standard of practice in the community in which the doctor practiced. The theory now imposed is that because of modern transportation, communication, text books, T.V. medical education, postgraduate courses, medical literature and meetings, even the "similar community" ruling is a thing of the past. A small community without a resident radiologist, a pathologist who visits twice a week, no intensive care unit, no anesthesiologist (perhaps a colleague who does the best he can in anesthesia in emergencies), no coronary care unit, no respiratory care unit, no interns or residents, no facilities for blood gases, no cardiologist, internist, pediatrician, allergist and so on, certainly does not give the small town doctor the same resources or ability to handle difficult and serious cases. It isn't the "wives" who are driving the doctors out of the small towns. It is the courts who hold the county practitioner now to the same standard of excellence as the physicians in the large centers with unlimited consultative and other facilities.

This and the doctrine of *res ipsa loquitur*, uninformed consent, recovery for mental suffering, the statute of limitations run-

ning from the time of discovery and some more permissive rulings, are in the opinion of many, as ridiculous as the recent ruling that unions have a vested interest in limiting production and it is therefore proper to fine union members for exceeding their quota.

Many professional liability carriers have withdrawn from the malpractice field. Some insurance companies will not write policies covering physicians who do any operative procedures; as a recent medical magazine article pointed out, a doctor makes thousands of life and death decisions in the course of his professional lifetime, yet if he makes one wrong decision, he may lose all he has worked a lifetime to acquire plus his professional reputation, and be unable to obtain liability insurance thereafter.

The physician shortage becomes more and more acute. Even so there is talk of re-licensing examinations at three year intervals and the training of sub-doctors. Who will accept the legal responsibility for these physician-aides? Certainly the number of M.D.s will be reduced by re-licensing, and early retirement because of the inability to obtain malpractice insurance or excessive premiums. Many excellent surgical assistants are not helping on cases they do not originate because this puts them in the category four classification of a surgical specialist with current premiums of \$1280.00 per year, and no end to the premium rise in sight.

I have heard, but have not confirmed the statement that plastic surgeons in

Florida cannot obtain malpractice insurance at any price. Some physicians who have had claims against them are rated up to above \$4000.00 a year in premiums, and you are familiar with the mass cancellations of malpractice policies in Utah and Alaska! Midwest Mutual cancelled all of their policy holders as of February 23rd. Aetna is no longer writing surgical specialists, and there is no doubt whatsoever about the courts practicing medicine. The high cost of medical care is greatly contributed to by the need for the physician to protect himself. It is questionable whether this makes for a higher standard of practice.

In Canada and Britain it is both unethical and illegal for a lawyer to accept a case on a contingency basis, and they have very few "nuisance" suits. Forty percent of the recent award for \$1,500,000.00 is a pretty hefty fee for a few weeks work. What do you get for saving a life? What became of making the plaintiff pay court costs if he loses a suit? Recently a malpractice action in Flagstaff took five weeks in trial. What did this cost the taxpayers? How much important business was delayed as a result of the interminable presentation of the plaintiff's lawyer in a case that in many opinions should never have been permitted to come to court?

Will the day come when a doctor will be forced to say, "I'd like to help you, but I just can't take the risk!"

Where will it all end?

(Reprinted from **Arizona Medicine**)

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## Hippies

The idea of giving up the American Dream, the house, the car, the washing-machine, is not to everyone's taste, however. I shot pool in a hall in San Francisco with a young Negro who made no secret of his attitude to the hippies. "As far as I'm concerned," he said, "they are throwing away everything which my people are fighting to get." He was a self-avowed member of the Black Panthers, an activist group who seek to bring about change by violence, either offered or provoked. Such violence erupts on the outer surface of the youth movement, and polarizes around other groupuscules, the Students for a Democratic Society—SDS, and the Yippies, adherents of the Youth International Party, from whose initials they take their name. ("The Quest," by John Taylor, **World Health** [July-Aug.] 1969.)



# Large Defect On Liver Scan

## Caused By Extrahepatic Mass

BY DONALD F. KOCH, M.D., AND JAMES L. QUINN III, M.D./OAK PARK

*The liver scan is established as a useful adjunct in detecting primary and metastatic hepatic malignancy. Interpretation is sometimes difficult because of the wide variation in normal anatomic configuration.<sup>1</sup> Recently we studied a patient with a grossly abnormal liver scan who at laparotomy was found to have an extrahepatic tumor of the right adrenal.*

### CASE REPORT:

A 46-year-old white female entered the hospital with complaints of right upper quadrant pain radiating to the right posterior subcostal area. The pain was continuous and aggravated by coughing and deep breathing. In the four months preceding admission, the patient also noted fatty food intolerance, alternating diarrhea and constipation, occasional small amounts of blood in her stool, progressive weakness and 17 lb. weight loss.

On admission, blood pressure was 110/75, pulse 96, respiratory rate 16, and tempera-

ture 99°F. The liver was palpable 6 cm. below the right costal margin in the mid-clavicular line, was smooth, non-tender, non-pulsatile and no bruits were heard.

The usual hematologic, biochemical and urine tests, as well as skin testing, were performed. The serum globulin fraction was slightly elevated and the albumin slightly depressed; all other tests were normal. Abdominal films, a gall bladder study and colon examination were also negative. The right hemi-diaphragm was elevated but without evidence of a pleural effusion or pulmonary infiltrate. An intravenous pyelogram revealed a moderate caudad displacement of the right kidney to a moderate degree without intrinsic abnormality.

On the third hospital day the patient became febrile with a shift of the white blood count to left and elevation to 15,000 WBC/cm<sup>3</sup>. Because of the possibility of an intrahepatic abscess, liver biopsy was deferred. A liver scan (Fig. 1) showed a



Fig. 1.



**Fig. 2**

large defect in the right lobe of the liver superiorly on the anterior view and extending the entire length of the liver posteriorly on the lateral scan. The patient was treated briefly with antibiotics without improvement.

At laparotomy, a large (17.5 cm in its greatest diameter) mass was found in the right suprarenal area. It was compressing the posterior, superior and inferior surfaces of the right liver lobe, displacing it anteriorly. Adhesions between the mass, the liver, the diaphragm, and the inferior vena cava were lysed and the tumor and right kidney were removed en bloc. No extension outside of the tumor pseudo-capsule could be found on microscopic examination. The histologic diagnosis was well differentiated adenocarcinoma of the adrenal gland. The patient did well post-operatively with complete relief of symptoms. Four weeks later the liver scan was repeated (Fig. 2) and again showed some enlargement of the left lobe. The right lobe had only a narrow residual band of decreased uptake in its mid-posterior portion. The serum proteins gradually returned to normal.

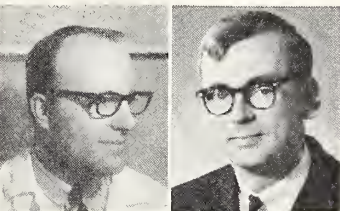
An area of absent (cold) uptake on the technetiumsulphur colloid liver scan is

usually caused by intra-hepatic disease processes. This case illustrates a less common cause, a juxtahepatic process that must now be considered as well. When a mass compresses the liver without actually invading it, the blood supply and hence nutrition to these areas is compromised, and if a large enough portion of the liver is affected, liver function studies may be expected to be abnormal. Multiple views of the liver were necessary to locate the precise site of this lesion. The appearance of this patient's scan is strikingly similar to a case of pheochromocytoma reported by Gillick and Foster.<sup>2</sup> The physical findings, history, and laboratory data in the present case were confusing and the true nature of the disease was not clear until laparotomy. Angiography would have been of help in locating the lesion but still might not have delineated invasion from non-invasion.

Considering the anatomic relationship of the adrenal to the liver, it is conceivable that as the tumor grew it encroached upon the inferior vena cava and portal vein with resultant congestion of the bowel wall, diarrhea, and hemorrhoids. Compression of the right hepatic duct, or common duct, by the enlarging tumor could have led to cholestatic cholangitis and the febrile response which occurred on the third hospital day. Additional considerations as to the cause of the fever would be tumor necrosis or coincident infection elsewhere.

Awareness of the possibility of a large extrahepatic mass should be maintained whenever a defect such as this is encountered in the proper clinical setting. ◀

**Donald F. Koch, M.D.** (left) is a senior resident in radiology. He received his M.D. from the University of Illinois College of Medicine and served an internship at the State University of Iowa Hospitals. He has also completed a radiology residency at Wesley Memorial Hospital, Northwestern University. Joseph Leland Quinn, III, M.D., is Director of the Department of Nuclear Medicine, Chicago Wesley Memorial Hospital, and Professor of Radiology, Northwestern University School of Medicine. He received his M.D. from Bowman Gray School of Medicine, North Carolina, and served at the North Carolina Baptist Hospital, Winston-Salem.



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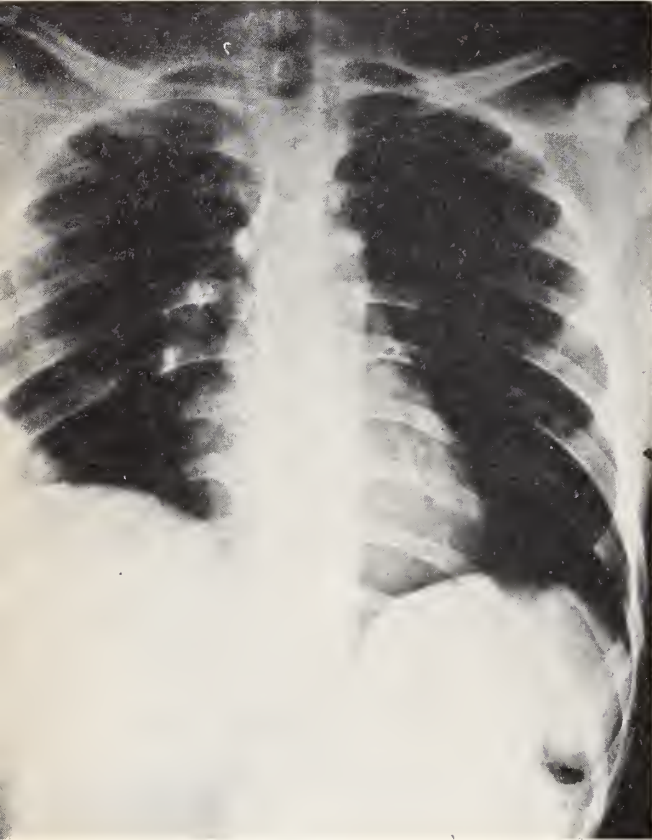




## THE VIEW BOX

By LEON LOVE, M.D.

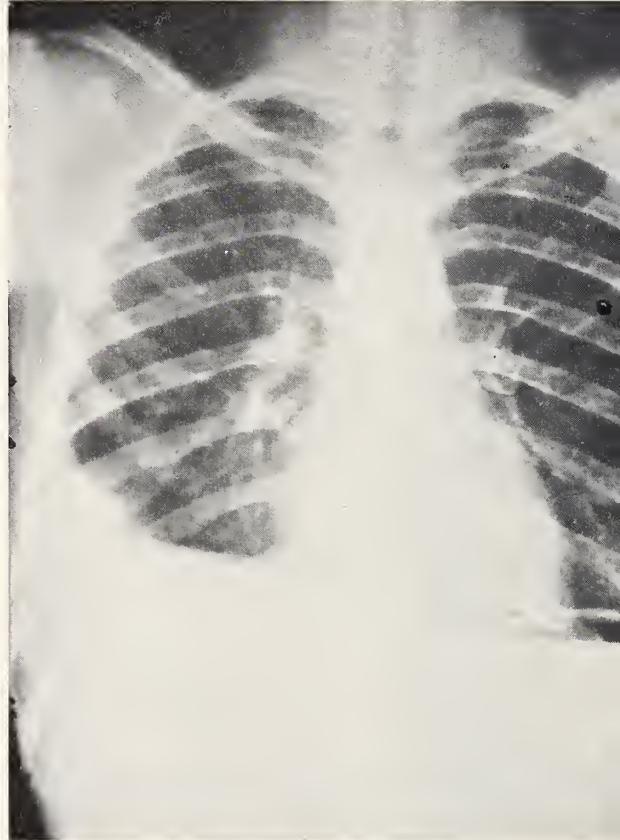
Director, Department of Radiology, Loyola University Hospital  
and Chairman, Department of Radiology, Loyola University  
Stritch School of Medicine



*Film 1*

The patient was a 23-year-old white female who entered the Hospital and delivered a normal full term baby. On the fifth day following the delivery, she complained of chest pain, fever, and a general sense of discomfort.

Physical examination revealed a well developed patient somewhat apprehensive. Blood pressure 130/84, and temperature was 101.5. There were rales at the right base and dullness on percussion in the same area.



*Film 2 (one week later).*

What's your diagnosis?

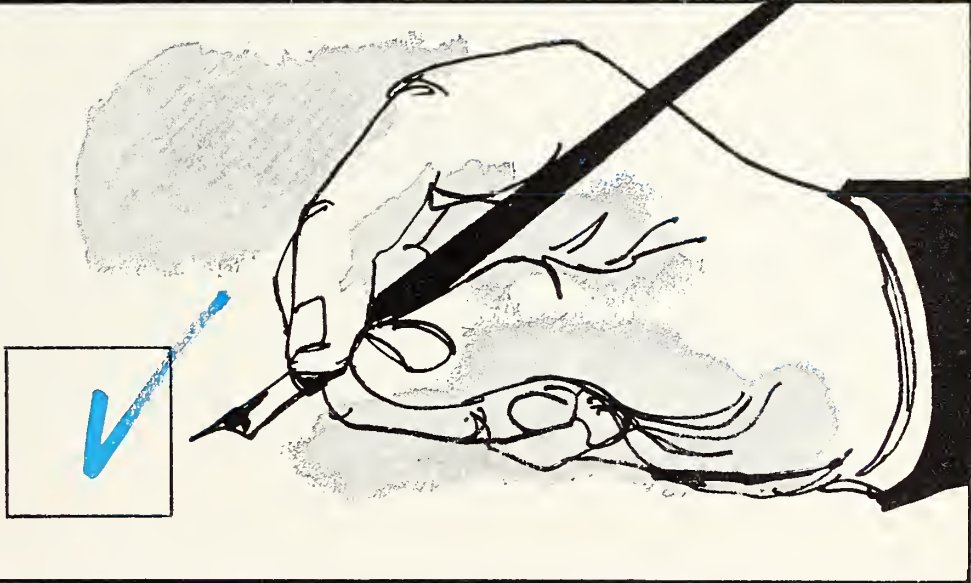
- 1) Choriocarcinoma.
- 2) Pneumonitis.
- 3) Subphrenic abscess.
- 4) Pulmonary embolism with infarction.

(Answer on page 615)



# IMJ

## 1969 SURVEY ANALYSIS



Doctor shortage . . . health costs . . . medicaid . . . therapeutic abortion . . . doctor's assistant . . . community health center . . . bad apples . . . continuing education . . . comprehensive health insurance.

These are bywords of our age. As much a part of the modern vocabulary as escalation and astronaut.

They are the labels for complicated issues and interests, posing formidable problems. Problems that the public looks to physicians to solve.

We cannot solve them by ourselves, but we can point the way, on the basis of our collective judgment. And that is what the IMJ 1969 Survey on Current Issues is about.

It is a mandate from the members . . . to the leadership of ISMS. It is the guiding force behind what your state medical society says and does.

As a result of the 1968 survey, ISMS endorsed a liberalized state abortion law, opened its membership to osteopaths, and organized a task force to deal with problems of physician shortage and health care in deprived areas. This year's survey calls for further changes in ISMS positions and programs.

More than 3,500 of you—over a third of our membership—returned the 1969 survey, the results of which will be published in three parts. The first, focusing upon the delivery of health services, begins on the next page. In the December issue of IMJ, we will analyze questions relating to the quality of physicians' services, and the following month, we will focus upon medical legislation.

Obviously, a questionnaire of this type has its limitations, because it asks for simple yes or no answers on complex issues. But regardless of its shortcomings, the survey provides an invaluable link between you and your officers so—together—we can seek lasting solutions to modern health problems.

*Matthew B. Eisele, M.D., Chairman  
Council on Public Relations and  
Membership Services*

## Medical Manpower in Deprived Areas

"I'm alone in the country. I need help!"

So wrote one doctor at the bottom of his survey questionnaire. He could have been speaking for many physicians throughout the state, who are alone—in the country or the inner cities—burdened by huge and ever-growing case-loads. Many communities have no doctors at all, others have one or two. The ISMS Physician Placement Service lists more than 150 Illinois communities in desperate need of doctors.

The solution to the doctor shortage will require the combined energies of many groups, agencies and individuals. The survey asked you what universities and hospitals should be doing:

*The shortage of doctors in medically deprived communities results in heavy caseloads for physicians practicing in these areas. To meet this problem, do you favor—*

Urging resident and intern training facilities to supply manpower to staff health centers—under the direction of a qualified physician—as part of their training programs? .....

Yes 80%  
No 20%

Your strong support for this proposal will be a guide to ISMS in future discussions with hospitals and universities. At present, there are six neighborhood health centers in Chicago that could be suitable to test the feasibility of such a program. ISMS will also urge downstate hospitals to expand their resident and intern programs to include experience in community health centers.





The survey also asked you what the role of ISMS should be in alleviating the doctor shortage:

*Do you favor—*

ISMS scholarship grants to medical students who agree to practice in ghettos and other deprived areas? .....	<b>Yes 82%</b>
	<b>No 18%</b>
Having your state medical society lend financial support to the establishment of health centers in deprived areas?	<b>Yes 56%</b>
	<b>No 44%</b>

The responses to both questions provide valuable guidance to the ISMS Task Force on Physician Shortage and Services to Medically Deprived Areas. Organized last June, the Task Force has been allocated an \$80,000 budget to implement its program. At present it is exploring the most appropriate methods of achieving the program's goals.

The Task Force will give thoughtful consideration to the proposal for an ISMS scholarship fund, which judging from the survey, is widely endorsed by the membership. Currently, ISMS in conjunction with the Illinois Agricultural Association provides annual loans to medical students who agree to practice in rural or other medically deprived areas for at least five years.

The response to the second question indicates a near-even split in opinion over direct ISMS financial aid to health centers. A breakdown of the responses, however, indicates that younger doctors favor the proposal more than older ones; that specialists favor it more than general practitioners; and that Chicago area physicians favor it more than downstate doctors.

### Physicians' Response to Doctor's Assistants

The idea of doctor's assistants has been in vogue for the past several years although the feasibility of this new class of medical manpower has yet to be proven in the United States. The "feldsher" program in Russia has met with mixed success, although the responsibilities of the feldsher are somewhat different from those of the American version. Whereas the feldsher may work semi-independently under periodic supervision of a doctor, it is anticipated that the American doctor's assistant would be a full-time member of the physician's staff, working under his constant supervision.

Since the success of doctor's assistants hinges to a great degree upon the willingness of physicians to hire them, the 1969 survey asked:

Would you hire a trained and licensed "doctor's assistant" or "feldsher" to work in your office, performing such tasks as preliminary screening for illness, well-baby examination and family planning? .....	<b>No 61%</b>
	<b>Yes 39%</b>



Since many practices would not be suitable work settings for physicians' assistants, a 100 percent affirmative response could not be expected. It is thought that doctor's assistants would be of most use to general practitioners, and perhaps specialists in pediatrics and obstetrics.

It is important to note, however, that the 39 percent of respondents who said they would hire a doctor's assistant *represent nearly 1,200 physicians*. This would indicate that there is a strong market for this new type of medical manpower, and should give impetus to the doctor's assistant training programs now underway. Thus far three physician's assistant programs are in operation at Duke University, Alderson-Broadbent College, and The University of Washington. The Nixon administration earlier this year formed a new office within the Department of HEW, charged with establishing programs for training discharged medical corpsmen as doctor's assistants.

The ISMS Council on Education and Manpower has been investigating the doctor's assistant concept for several months, with special attention to the training, responsibilities, and legal status of assistants. The council has requested ISMS legal counsel to examine the Medical Practice Act to determine if it is sufficiently flexible to allow experimentation by physicians in the use of allied medical personnel.



## **Physicians and the Doctor Shortage**

In searching for solutions to the doctor shortage, the ISMS Task Force will be examining ways practicing physicians can be utilized in deprived areas on a part-time basis. In last year's survey, nearly 60 percent of the respondents indicated a desire to work "a certain number of hours each month" in a nearby medically deprived area.

Carrying last year's question a step farther, the 1969 survey asked you under what specific circumstances you would serve:

*If a community health center were established in a medically deprived area nearby, would you be willing to work there on a—*

Part-time schedule (equivalent of one or two days a month) being reimbursed on a fee-for-service basis? .....	<b>Yes 64%</b>
	No 36%
Part-time salaried basis, assuming the salary is agreeable? .....	Yes 42%
	<b>No 58%</b>
Part-time schedule, but without reimbursement? .....	Yes 31%
	<b>No 69%</b>
Full-time, salaried basis? .....	Yes 8%
	<b>No 92%</b>

When analyzing the responses to these questions, it is important to note that a negative answer does not necessarily mean the respondent was unwilling to serve in a deprived area. Some physicians mentioned on their questionnaire that they *already* serve part-time in a deprived community. Doctors from areas where the physician shortage is acute said they simply could not take on more patients.

"I already have more patients than I can treat," commented one downstate physician.

A breakdown of the responses, yielded these conclusions:

- Younger doctors appear to be more willing to serve on a part-time basis (with or without reimbursement) than older physicians.
- Older doctors appear to be more willing to work on a full-time, salaried basis than younger physicians.
- Downstate doctors appear to be more willing to serve (with or without reimbursement) than Chicago area physicians.
- The 31 percent who indicated that they would serve with reimbursement represent more than 870 physicians.

The data gathered from these questions will be used by the Task Force to tailor a program in which the greatest number of physicians will want to participate. County medical societies may also make use of this information in setting up programs of voluntary assistance to neighboring deprived communities.

## **Health Costs and Hospital Stays**

The average daily expense for hospitalization in Illinois was \$62 in 1968, and is estimated at \$70 this year. At least one hospital has reported a \$100 per patient day expense.

The rapidly increasing cost of hospital care has pushed health insurance premiums higher and higher, and resulted in whopping bills for the unfor-

fortunate few who have no insurance coverage. The average cost per patient stay in 1968 was over \$450.

Handling diagnostic workups and performing minor surgery on an outpatient basis have been proposed as key methods of reducing hospital stays. The survey asked your opinion on the proposals in these questions:

*To reduce patient stays in hospitals, do you favor—*

Handling all diagnostic workups on an outpatient basis, provided the patient's condition permits and insurance coverage is available for such services? .....	<b>Yes 92%</b> <b>No 8%</b>
Performing minor surgery on an outpatient basis, provided insurance coverage is available for such services?	<b>Yes 96%</b> <b>No 4%</b>

Your nearly unanimous support of these proposals indicates that ISMS should encourage hospitals to arrange for diagnostic services to be handled in outpatient clinics or physicians' offices. Similar arrangements should be made for performing minor surgery.

Naturally the success of these measures depends on a broadening of insurance benefits to cover out-of-hospital services. In this regard, the survey asked:

*To reduce patient stays in hospitals, do you favor—*

Encouraging insurance carriers to provide comprehensive coverage, including outpatient and home care? ....	<b>Yes 96%</b> <b>No 4%</b>
--	--------------------------------

The overwhelming support given this proposal will serve as a directive for ISMS to urge health insurers to provide broader coverage. It is encouraging to note that Blue Shield Plan of Illinois now covers more than 425,000 of its 2.5 million subscribers for outpatient diagnostic services. Hopefully, as more persons take advantage of this type of coverage, inappropriate use of hospital services will be curbed, and the rapid rise in hospital costs will be checked.

**Research vs. Production of Doctors**

In the academic year 1966-67, the federal government provided U.S. medical schools with \$445 million for research and training. Of that amount, about \$100 million was earmarked for training, while nearly \$345 million was designated for research, according to the Association of American Medical Colleges.

Citing these figures, some observers have argued that the government is putting too much emphasis on research and not enough on graduating new physicians, thus aggravating the doctor shortage. A survey released in January, 1969, by *Hospital Physician* indicated that the average academic physician spends only about a quarter of his work week in teaching.

As a means of achieving a balance between research and teaching, some ex-



perts have suggested tying the amount of federal research money to the number of doctors a school graduates. The survey asked for your viewpoint in this question:

*It is charged that the federal government, through research grants, indirectly discourages medical schools from graduating more physicians.*

Should medical schools be required to graduate a certain number of doctors in proportion to the amount of federal research funds received directly or through staff researchers? .....

Yes 41%  
No 59%

It appears that most doctors do not consider the proposal the solution to the research vs. teaching dilemma. ISMS will bring the results of this question to the attention of medical school officials and federal authorities but will not—in the absence of a clearcut mandate from the membership—support or oppose the proposal.

Although no conclusive answer can be drawn from the question, a breakdown of the survey responses by age, specialty and place of practice yielded some interesting findings. For example, older doctors are more in favor of the proposal than younger ones; general practitioners favor it more than specialists; and downstate physicians favor it more than Chicago area doctors.

The analysis of the results of the **Illinois Medical Journal** Membership Opinion Survey will be continued in the December and January issues.

## Malpractice Sharks

What did I learn from this sordid experience? I learned that certain lawyers will take on almost any patient who thinks he's been mistreated. I learned that a malpractice insurance company will encourage these shenanigans by settling nuisance suits. And that the doctor who is sued takes it on the chin, whether he runs or fights.

Did I accomplish anything? I think that I traded blow for blow and gave as good as I got. But is that enough? No. The real miscreants are the insurance companies. As long as they continue to settle flimsy malpractice claims out of court rather than fight them in court, it's the doctors who pay the bill through higher malpractice insurance premiums. (Clifford L. Graves: "My battle with the malpractice sharks," **Med. Economics** [Sept. 3] 1968.)



Fig 1: Wound at time of debridement

## Gas Gangrene

### Of Abdominal Wall

### After Appendectomy

By RUDOLPH W. ROESEL, M.D., DONAL D. O'SULLIVAN, M.D.  
AND THOMAS G. BAFFES, M.D./CHICAGO

*The Clostridiae are gas forming, gram-positive bacteria which can be cultured from the soil. They are frequent inhabitants of the gastrointestinal tract after the first few weeks of life. Animals are passive carriers of the anaerobic organisms and are responsible for their universal spread. Because of the ubiquitous presence of the causative agent, gas gangrene may complicate any surgical case.<sup>1</sup>*

*The disease is an ancient one. Hildanus, in 1607, described clinical gas gangrene. The Napoleonic Wars and World Wars I and II each showed a high incidence of this type of infection. The estimated in-*

*cidence of gas gangrene in wounds during World War I ran as high as 10%.<sup>2</sup> The principal bacteria involved in the production of gas gangrene are clostridium perfringens (Welchii), Clostridium novyi (Oedematiens), and Clostridium septicum.*

*Primary debridement and late closure of wounds led to a dramatic lowering of the morbidity and the mortality of the disease during World War II. In the Korean conflict, the administration of increased amounts of antibiotics, combined with immediate evacuation of the patient, reduced the incidence of gas gangrene to a negligible figure.*



## Case Presentation

A 19-year-old male was admitted to Augustana Hospital on October 25, 1967, with right lower quadrant pain, nausea, vomiting, and diarrhea of two days duration. A diagnosis of appendicitis was made and an appendectomy was performed the same day. The appendix was retrocecaly located and evidence of marked inflammatory changes were found. The distal end of the appendix appeared gangrenous. There was localized enteritis surrounding the cecal area. The appendix was removed with inversion of the appendiceal stump. The abdominal wound was closed without drainage, the immediate postoperative condition of the patient was satisfactory.

## Clinical Course

On October 27, the body temperature rose to 102° F. and the surgical incision appeared acutely inflamed. On October 29, there seemed to be some swelling of the right upper quadrant area and marked tenderness of the skin over the right side of the abdomen. There was chest pain on

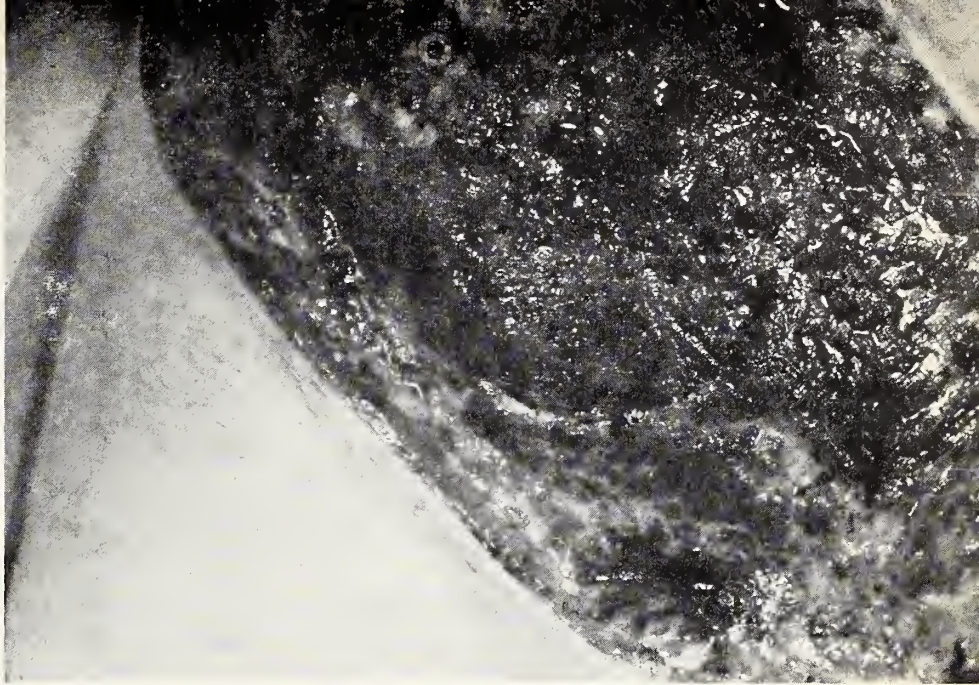


Fig. 2: Wound one week after debridement

inspiration and reddening of the skin surrounding the incision. The wound was opened and drained of copious amounts of liquid material, which showed Gram-positive rods in large quantities by direct smear. Culture identified *Clostridium Perfringens*.

On October 30, under general anesthesia, wide surgical debridement of the involved area was carried out with excision of a large segment of the skin and necrotic muscle tissue. Two counter incisions, one in the right upper quadrant of the abdomen and the other over the right hemithorax, were placed where crepitation could be felt. There was evidence of extensive fascial necrosis. The site of the previous McBurney incision was re-opened. A catheter was placed into the abdominal cavity for drainage purposes. A large segment of suprapubic fascia was removed. The fascia between the primary incision and the counter incisions was completely removed with undermining of the skin flaps. The scrotum appeared swollen, edematous, and very tender, but was not drained. There was also some evidence of redness and edema formation over the upper thigh. Five catheters were placed under the skin flaps and a continuous drainage system was instituted, using 1.5% hydrogen peroxide solution.

## Post-Operative Care

Post-operative care included intravenous



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fluids with large doses of antibiotics, including Keflin, 4 grams, 4 times daily, Penicillin, 10 million units every 12 hours, and gas gangrene anti-serum, 40,000 units every six hours intravenously. The antibiotics were given for approximately seven days; the anti-serum was discontinued after five days. To correct an anemia which developed post-operatively, the patient received two pints of blood on November 2. His fever began to decline on November 1, two days after debridement was carried out. He gradually improved. Eleven days after the initial surgical debridement, split thickness skin grafts were applied to the denuded area and the counter incisions. On November 16, under local anesthesia, small areas of granulation tissue were re-grafted in a second session.

The patient received hyperbaric oxygen treatment immediately after the initial surgical debridement on October 29. Treatment consisted of exposure to 3 atmospheres of pressure for 25-30 minutes, carried out daily for four consecutive days. The treatment was well tolerated by the patient. The patient made an uneventful recovery and was discharged from the hospital on November 25, in good condition. He is a college student and is participating in all physical activities, including competitive sports.

## Discussion

*Clostridium* infections involving the abdominal wall are rare complications of civilian surgery.<sup>3-4</sup> When clostridial organisms invade abdominal muscles, saprophytic digestion of devitalized tissue with gas formation occurs. Gas gangrene is seldom suspected after elective abdominal surgery. The diagnosis of the disease may be difficult because the classic sign of crepitus due to gas infiltration of the subcutaneous tissue occurs late. A rapidly progressive, violent toxic course, without obvious cause, suggests the presence of this disease. The following diagnostic symptoms and signs are pertinent to gas gangrene: wound pain, apprehension, tachycardia, hypertension, jaundice, extreme restlessness, bronze erysepilas, profuse watery discharge from the wound, tissue crepitus, and a sweet odor of the discharge. The presence of gas in necrotic tissue requires wound culture and smear examination of the exudate.

Altmeier and Furste noted that various tissues have different powers of resistance to the *Clostridia*.<sup>5</sup> The most susceptible areas described by them were muscles of the thigh, calf, and buttocks. In animals it could be demonstrated that devitalized muscle was one million times more susceptible to bacterially induced gangrenous



**Fig. 3:** Wound at time of skin graft

infection than healthy muscle. Gas gangrene is produced by exotoxins from viable organisms rather than by direct invasion by the bacteria. The alphatoxin, a lecithinase, produces hemolysis followed by anemia, hemoglobinuria, oliguria, and jaundice. The theta-toxin has less activity but has similar action.<sup>6</sup> Other organisms may cause gas in the tissues, for example *Klebsiella pneumonia*, bacterioides, anaerobic streptococci and *Escherichia coli*. Consequently, neither the presence of gas nor the culture of clostridium alone is sufficient to establish the diagnosis of gas gangrene. In this disease a wound smear will show numerous Gram-positive rods with only a few leukocytes. In anaerobic streptococcal myonecrosis chains of streptococci and masses of leukocytes are present. In contrast, when clostridia appear as saprophytes, the smear shows only a few Gram-positive rods and a few tissue cells with the average bacterial flora.

In summary, 68 years after Welch<sup>7</sup> reported three cases of clostridium infection of the abdominal wall, we still are threatened by similar problems. Early diagnosis, extensive debridement, large doses of an-

tibiotics,<sup>8</sup> specific anti-serum, and the hyperbaric chamber<sup>9</sup> have proven to be helpful tools in the management of this otherwise lethal infection. ◀

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## Attributes in Retardation

Mental Retardation, as any other handicap, must be viewed as an attribute of an otherwise more or less intact organism. The retarded or emotionally disturbed child has never ceased to be a child, a fact never to be forgotten. Throughout the various phases of their ongoing development, the handicapped and the ordinary child have much in common and are more similar than different in basic needs and requirements. They both are subject to the stresses and formative influences of interpersonal relationships in their environment, at home, at school, and at play and work, and respond to them with a similar repertoire of emotional responses.

Allowance must be made for a number of distinguishing features: the retarded child progresses at a slower pace and rate than the ordinary child to the successive milestone of development; with increasing age he lags more and more behind his contemporaries in adaptive behavior and mastery of reality. He therefore lacks adaptability and flexibility under changing circumstances, and prefers repetitive or monotonous routine activities to which he is limited. He has not advanced to develop his emotional equipment, i.e., adequate and mature adjustive patterns, strategies and defenses that would enable him to maintain his emotional equilibrium under ordinary stresses. All this accounts for his prolonged dependency. (Leopold Hofstatter and Lilli Hofstatter: "Emotional Problems of the Child with Mental Retardation and His Family," *Southern Medical Journal* 62:5 [May] 1969.)



# Electroneuroprosthesis

## History And Forecast

BY WENDELL J. S. KRIEG, PH.D./CHICAGO

Our knowledge of the tracts and connections of the brain stem became definitive in the early years of the twentieth century. Meanwhile, the cerebral hemisphere has remained a vast desert of ignorance, in spite of the great boon which would result from an understanding of localization and transmission of epileptogenic foci, of disconnection syndromes and the varieties of aphasia, of analysis and synthesis of sensory data, of the formulation of motor activity, of thought processes, and the possibility of design of artificial memory, analysing and rationalizing machines.

This enormous information gap became disturbing when I attempted to write a comprehensive textbook of neuroanatomy in the thirties. On joining Northwestern Medical School's Institute of Neurology 25 years ago I took the connection of the cerebral cortex as my field of investigation. As I became more aware of the possibilities of precise localization in the cerebrum I dreamed of a great expansion of the Institute, of which I had become director, and made a formal proposal to my dean of the aggregate plan, in 1949.



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### Stereotaxic Machines

One phase was the development of stereotaxic machines on new principles. Some of these are now in commercial production, 1) the first small animal machine, with a single arm, not a gantry; 2) the stereotaxic duplicator, which depends on a matching of the brain electrode yoked with a pointer to a positioned brain section, using pivots and sway bars; 3) the quadruple stereotaxic machine which has four independent tridimensional assemblies. Planned but not actually produced, were 4) a universal stereotaxic machine on a cubic mounting, which would permit 20 independent assemblies to be used at one time; 5) a machine on a 3-D pantographic principle controlled by intersecting planes of light through a transparent model, and 6) one using Selsen controls with arrangements for systematic and arbitrary distortion to match individual heads.

### Cortex Scanner

The second main research thrust was to be the cortex scanner. This was to be an image orthicon tube whose face was shaped to conform to the surface of the hemisphere. Momentary cortical potentials could be picked up by a television-like scanning cathode beam, and visualized on a screen marked with the cortical sulci.

By far the most significant innovation in the 1949 plans for the neurological institute was the replacement of interrupted

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sensory connections to the cortex, by means of patterned electrical stimuli: sensory electroneuroprosthesis.

The application of electroneuroprosthesis, as subsequent events proved, evoked the most interest, requires laying some background.

Now, injury to the retina or the optic pathway results in blindness, because all image formation reaches consciousness in the occipital pole of the cerebral cortex. Dead optic fibers never recover, even though severed nerves in most other places can regrow. We know, and knew in 1949, that the visual field is laid out in an organized manner on the surface of the occipital cerebral cortex, that exactly one half of the visual field is represented in each side, that the central discriminatory part is at the occipital pole, enormously expanded, while the peripheral part of each half field is folded into the calcarine fissure of the medial surface. Presumably, if a gentle electrical stimulus were applied at some point on the visual cortex, a spot of light, a phosphenes, should be fancied, corresponding in its apparent location to that part of the visual field to which it normally responds. If a pattern of points were stimulated, multiple points of light should be sensed, indeed if a grill-work of electrodes were in place, an arrangement might be made to outline, say, the letter "F". Sequentially, they might spell out a message, so that imagery and information might thus be conveyed directly to the cerebral cortex, even to the blind.

If an electrode were activated by the current generated by a photoelectric cell receiving its light from a restricted area, a blind person should be able to orient with relation to a window, a lamp, or the sun. If an array of photocells were directed towards various points in the visual field, some perception of the outer world might ensue, the information-bearing product being factored by the number of separate circuits in the apparatus and the degree of discrimination possible from electric stimulation of the surface of the visual cortex.

Indeed, if the last factor proved to be quite high, that is, if closely placed electrodes could be discriminated, it ought to be possible to simplify the apparatus by sweeping a single photocell across the

visual field, synchronize this with a traveling switch, perhaps a cathode ray, and the result would be a useful image with some detail. Of course, the outer world is highly distorted as it is mapped out in the visual cortex, but the basic pattern of this is known, while the details of electrode arrangement could be rearranged subjectively by the blind patient as he uses the machine, such as matching his image components with a vertical line in space.

Though it was not known how many points could be discriminated in practice, the device would be of benefit at any limitation of fineness. Even the perception of on-off light would be useful to a blind person.

### Auditory Cortex Stimulation

Similarly, the auditory cortex might be stimuable by electric current. This should be useful in a deaf person, if only to sense warning sounds. The auditory area is on the floor of a buried fold of cortex at the side of the cerebrum. It had not and still has not been thoroughly studied experimentally, but there was work to show that the tonal scale was laid out along its surface, the highest tones forward, the low tones behind. Non-minimal stimuli to the general region of areas 41, 42 or 22 produce sensations interpreted as ringing, chirping, humming, buzzing or booming. Presumably, a careful study would show localization of pure tones, possibly some localization for timbre.

Thus, it would seem that electrical stimulation of the auditory receptive area of a deaf person would produce the sensation of sound. It is an easy matter to switch on an electric current by resonance of any given pitch or range. If an array of electrodes on separate circuits were placed on the auditory receptive area, a little experimentation by the patient would determine which pitch corresponded to each station.

Experiments at Bell Telephone Laboratories before 1933 had shown that the human voice can be interpreted if transposed into some half dozen spaced pure tones produced by combination of tonal ranges, so the input need not be complex, unless music appreciation is the goal.

While the adult who becomes deaf in later life is not as handicapped as a blind person, and adult deafness is seldom abso-

lute, the congenitally deaf child also remains speechless, because he can hear no words to imitate. If auditory electroneuroprosthesis were utilized only during a brief speech-training period in childhood, its effects would be permanent as regards speech. Though returning to deafness once the apparatus was removed, he would possess the faculty of speech all his life, just as in cases of adult deafness.

It is possible that the tones and timbres are laid out in the auditory receptive area in a minutely organized manner, and that a multi-electrode plate could be applied. The tonal affinity of the cortical point each electrode touches could then be worked out by trial and corrected to a resonator for that individual sound. No scanning is necessary with auditory prosthesis, no matter how complex, and the tonal scale is one-dimensional, rather than two-dimensional, like the monocular visual field.

The value of somesthetic prosthesis is dubious, as it would seem to be of little value to reproduce the sensations from an amputated limb. Nevertheless, here we are on sure ground, for the practicability of producing subjective sensation by stimulation of a cortical receptive area has been amply demonstrated, and had before 1949.

However, the possibility of exploration of the vast areas of the cerebral cortex not directly connected with sensory afferents is an intriguing one. Let us quote from the 1949 application. "It is possible that electrical impulses representing sensory stimuli may be carried to undifferentiated cortex, and this material analyzed by the trial and error method of the infant cortex. A fascinating field from the research standpoint is the enlargement of sensory range by applying modalities of stimulation or varieties of data not ordinarily directly perceived by man. The examples that come immediately to mind are supersonic vibrations, Hertzian waves, ultraviolet rays. Such unusual stimuli are not to be applied directly to the brain, but transduced into electrical stimuli of appropriate intensity for the cortex to respond. Who knows to what degree the intelligence of man or his knowledge of the universe may be broadened by piping to the brain modalities of data which are not appreciated by any of the conventional senses?"

## Motor Prosthesis

After severance of a nerve trunk, the muscles which supplied the nerve paralyze. They may still be stimulated, however, by electric current from the skin over them, and if regularly stimulated over the point where motor endings are concentrated may be kept from atrophy indefinitely. It ought to be possible to place electrodes over denervated muscles, and by activating them in proper sequence and intensity, produce useful movements. For symmetrical movements or walking, the stimuli could be made from normal myograms during the movement desired. It might be more sophisticated to use buried receivers, each tuned to a single frequency (the original prospectus called for secondary coils), to avoid piercing the skin over the deeper muscles by wires. This is peripheral electroneuroprosthesis.

In conditions where the motor nerves and muscles are normal, but the central organization and control is at fault, resulting in faulty muscle tonus, it may be possible by placing retention electrodes at proper control points, to inhibit or exalt tonus or activity. The central control of tonus is built up at subcortical levels and is much better understood than the processing of sensory material. Experimentally implanted electrodes in animals would forestall the necessity of basic experimentation in man. Human and animal mechanisms are here known to be quite similar.

The foregoing proposals are a shorter version of the plan offered in 1949, with care to avoid anachronisms in thinking or taking advantage of after-knowledge. I believe both electricians and clinicians will agree that it was worthy of serious study and that some parts at least would merit support. It was presented to the medical school's dean at that time, who took it seriously enough, and referred it to the two clinical departmental chairmen, who should be most entitled to pass on it. They promptly killed it. One qualified by saying, "Well, yes, perhaps in 100 years"; the other saying "Do you think neurosurgeons want to go around drilling little holes in people's skulls?"

Application has been made to two more deans in lineal succession, with a resound like dropping a rose petal in the grand canyon. It has been expounded to three



successive chairmen at my department, and fallen dead there. It has been urged with the first three successive directors of the Institute of Neurological Disease and Blindness without any action. The first said, "We know many of these things are being done around the nation now." The second didn't last long enough after the proposal. The third said it seemed like the sort of thing the Easter Seals program ought to take up.

It happened that within a few months after the proposal was written, I had occasion to give the presidential address for our local chapter of Sigma Xi. So I popularized it a bit under the title, "New Horizons in Brain Research." The talk was covered by a routine press release. Lo and behold, next day there was an article about it in nearly all major newspapers, usually on the front page! A few days later it was in a number of newspapers overseas. Then came the columns, syndicates, and an article in *Time* magazine. A considerable volume of fan mail surged in, mostly from afflicted people who were willing to be "guinea pigs," as they usually put it, or with blind or deaf relatives. There were suggestions from amateur electricians, imaginative forecastings, crackpot letters and even paranoid ravings about secret rays, control of others' minds and the like. But no checks. I spent my research time for the rest of the academic year answering letters.

At irregular intervals during the years that followed, the plan was revived, either as a result of events, or proddings by colleagues. Neither blindness, rehabilitation nor electronics is in my usual line of work, and I continued to work on the cortical connections.

Having been asked to give a centennial address for a university in February 1968, I wanted the subject to be the most important thing I had to say. My address was entitled, "Electroneuroprosthesis,—Tomorrow?" It was a detailed scientific reappraisal of the subject in light of whatever has been learned and thought since 1949.

The main issue seemed to be visual prosthesis so it received the most emphasis. The possibility had always dominated the popular interest since the first publicity. If it could be brought about the other prostheses and the more pure research would be swept along in its wake. So in that ad-

dress a series of searching questions was asked and replied to test its practicability. Would punctate stimuli be seen as localized points or glows? We have long known that the quadrants of the visual field and of the macula are separate in the visual system all the way to the cortex. But are the fibers scrambled within these subunits? Talbot and Marshall have shown by evoked potentials in the monkey's cortex after localized light flashes that each response area is localized and discrete.

Could the electrode array be held permanently in place? Well, retention electrodes have for long been used in animals from rats to chimpanzees. The human skull is much thicker and bone healing will glue in the fastenings. No trouble is anticipated here.

But could a foreign body be tolerated in contact with the brain for long periods? Fischer showed that deep electrodes, if of stainless steel, can remain in the brain for long periods without damage of a single cell beyond the path it cuts. Delgado's rather large deep electrode assemblies showed only a thin growth of glia cells over the surface. Here the pia need not even be pierced and the electrode could end as a button.

But possibly periodic stimulation will in time render the neurons unexcitable or kill the surrounding cells. John Lilly found that by using a quick positive and negative wave with a short pause between, 168 million stimuli over 16 months did not weaken the response. The stimulus parameter can be determined by experience. Apparatus has been developed to deliver any kind of stimulus. One only has to twist the knobs.

How could a large number of electrodes be held in place? They need not be separate. They could be incorporated into a plastic plate, curved to fit the local configuration on each brain by milling out a plastic slab with its contained electrodes.

Granted that multiple controlled electrical stimuli could produce a localized pattern of light spots in a normal visual cortex, would blind people see a similar picture? Are the cortical cells dead? Riesen raised newborn chimpanzees in the dark for over two years, and found they failed to learn to recognize the commonest objects. Hubel and Wiesel obtained a simi-



lar result with kittens whose lids had been sutured together for months after birth. Thus the congenitally blind can not be expected to benefit from stimulation of the visual cortex. However, they total less than 1% of the blind. Adult cats, however, after being deprived of light for a similar period showed no change from the normal in response of cortical cells to light on the retina. This gives us reason to believe that the visual cortex of the blind has not necessarily degenerated, and thus should give responses subjectively much like the normal.

It is known from the researches of Kuffler that the normal retina shows a standby activity. Might not this maintain the visual cortex in those who are blind merely from failure of the image-forming mechanism, as with cataract of the lens, while those whose retina has been destroyed, as with diabetes, vascular disease and possibly glaucoma might show an inert cortex? Statistics on the numbers of the blind from various causes indicate that in 27% the retina is destroyed with the possibility of another 14% from glaucoma. So the retina is receiving light, but not an image, in the remaining 50-60%. There seems to be no reason why these should not benefit from electroneuroprosthesis. These should be the patients first scheduled for operation.

Granted that the use of the device should enable a considerable proportion of the blind to visualize patterns and spots of light, would this be of any real use? This subject was discussed in the original prospectus, which stated that orientation by light would be practicable even if only a few stations were feasible, while with a grill of 25 or more, words could be spelled out, at least.

### **How Many Electrodes?**

We are not sure how many electrodes could be utilized. Anatomically, the display of the macular region would indicate that a set of 100 for only the macula would be easily accommodated. John Lilly fitted a monkey's brain with a cap containing 640 electrodes. Physiologically, we conclude from the magnificent studies of Hubel and Wiesel on evoked potentials from single cells in the cat's and monkey's visual cortex, that a very large number could be used to advantage. Individual cortical neu-

rons are keyed not only to specific stations of the visual field but to a bar of light oriented at a specific angle and moving either from off to on or on to off. Other cells respond to quadrilaterals of light, not only at a certain station but of a certain orientation and size. Narrow columns of cells tend to have similar characteristics, hence, there is specificity of function, when normally innervated anyway, that goes far beyond any contemplated stimulation program. We may dream, however, of someday using a large number of closely-packed electrodes to stimulate these specific cortical cell columns, the patient determining the receptive parameter of each, that is direction and shape, by being fired one after another and telling a computer what is being sensed. Once programmed, an image fed into the computer would be analyzed by location and characteristics of the components, and it would select the proper electrodes to be stimulated, which would then in the mind's eye sum up to a picture, just as it does with all of us, right now.

Finally, we must ask, is enough of the visual cortex accessible for a useful prosthesis? The macula covers the occipital pole, and the macula gives us most of our information. For example, it is not possible to read time on a clock 5° away from the macula. The occipital pole is accessible, convex and not beset with deep sulci which cannot be reached by electrodes. The calcarine sulcus, medially placed, and deep, is another matter. Most of the peripheral field is spread along its upper and lower lips, hence accessible to the creased handle of a bent spoon-shaped plastic plate incorporating the electrodes. But the large calcarine artery runs the length of the sulcus deep within, and a series of branches run out over its lips. Perhaps it would be better to let the calcarine sulcus alone and ignore the far lateral field. The medial field of one eye covers the lateral field of the other, except for the monocular crescent. Moreover, when the eyes are turned to the side the macula resolves the detail seen but dimly when peripheral. We can only be grateful that relenting Nature has placed the macular fields on the occipital pole, and has magnified them so enormously that man's crude attempts to replace the exquisite mechanisms of the body

are not too bungling and out of scale!

This was the analysis of the problems underlying visual electroneuroprosthesis in the address of last February, just a year and a half ago. Auditory and motor prostheses were also reconsidered, but there is not time to go into details here.

Again, as a result of a routine press release, there were newspaper stories, but fewer, and much less public reaction. This was at the time of the first heart transplant and in the last 20 years the public had become unresponsive to medical miracles—especially when only predicted. To me the important result of this episode was having the opportunity to exchange thoughts with some fine men in Veteran's Administration and Rehabilitation, and Leslie Clark of the American Foundation for the Blind. One organization even expressed interest and asked for an estimate of costs.

### The Denouement

Now, the denouement! In mid-July of this year I first became aware of the paper of Brindley and Lewin of Cambridge, England, in an issue of the *British Journal of Physiology* that apparently reached the library table at the end of May. They had done it! An array of 80 electrodes was placed over the visual receptive cortex of a 52-year old woman blind for five years from bilateral glaucoma. When the individual electrodes were fired a point of light "like a star in the sky" was visualized at some definite location in the dark. The subjective localization remained the same for each electrode, and when several electrodes were fired concurrently a reproducible pattern of phosphenes was generated. The reactions have an immediate and sharp "off" and "on" response and they do not seem to fatigue or blur. Electrodes as close as  $2\frac{1}{2}$  mm. on the visual cortex produced phosphenes which can be easily distinguished.

There is no need to say any more,

though certain valuable observations were made, except to quote from the conclusions of Brindley and Lewin:

"The resolving power of the cortex for electrical stimuli is especially satisfactory; it seems likely that the number of electrodes could be increased to at least 200 per hemisphere and all the phosphenes remain resolvable. Our findings strongly suggest that it will be possible, by improving our prototype, to make a prosthesis that will permit blind patients not only to avoid obstacles when walking, but to read print or handwriting, perhaps at speeds comparable with those habitual among sighted people."

At a stroke the future of the care of the blind has been transformed from hopelessness to hope. If, indeed electroneuroprosthetic centers are speedily developed into a reality the lives of the blind will have meaning for themselves, and have use to society; the care of the blind will be transformed from a dismal drudge to a guidance of development; and the welfare burden of the nation and the community will be lightened.

All who have undergone tragic disaster know that the ray of hope is all important. But that hope is transformed into despair, which is worse than hopelessness if no issue is found. This nation, gifted with wealth and skills, must respond to the certainty, as it did not respond to the prediction by immediately instituting centers for electroneuroprosthesis, taking advantage of this sudden lifting of the curtain that has kept us from constructive manipulation of the cerebral cortex not only for therapy and development of electroneuroprosthesis—visual, auditory, motor, and the unknown, but also for the increase of our knowledge of that last, greatest mystery, the cerebral cortex itself, and in so doing gain for this nation a share in the achievement where the way has been shown, though 20 years have been lost by its failure to respond to the prediction. ◀

With the decennial census of population and housing to begin next April 1, the Census Bureau is seeking space for 400 district offices throughout the nation. The Bureau says the 400 offices, with district managers, will divide the nation into units of 500,000 persons each.

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Lomotil ..... Second Cover	Vasodilan CVD .....554-555
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## Postgraduate Courses Scheduled

The Division of Maternal and Child Health of the University of California School of Public Health, Berkeley, announces postgraduate programs for pediatricians, obstetricians, and other physicians interested in receiving training in the field of Maternal and Child Health. These programs all lead to the degree of Master of Public Health. Tax-exempt fellowship support is available.

*Maternal and Child Health.* A 9-month program in planning, organizing and operating comprehensive health services for mothers and children.

*Family Planning.* A 9-month academic program providing intensive work in family planning as part of the general graduate preparation of maternal and child health specialists.

*School Health.* A 9-month academic program providing intensive work in school health as

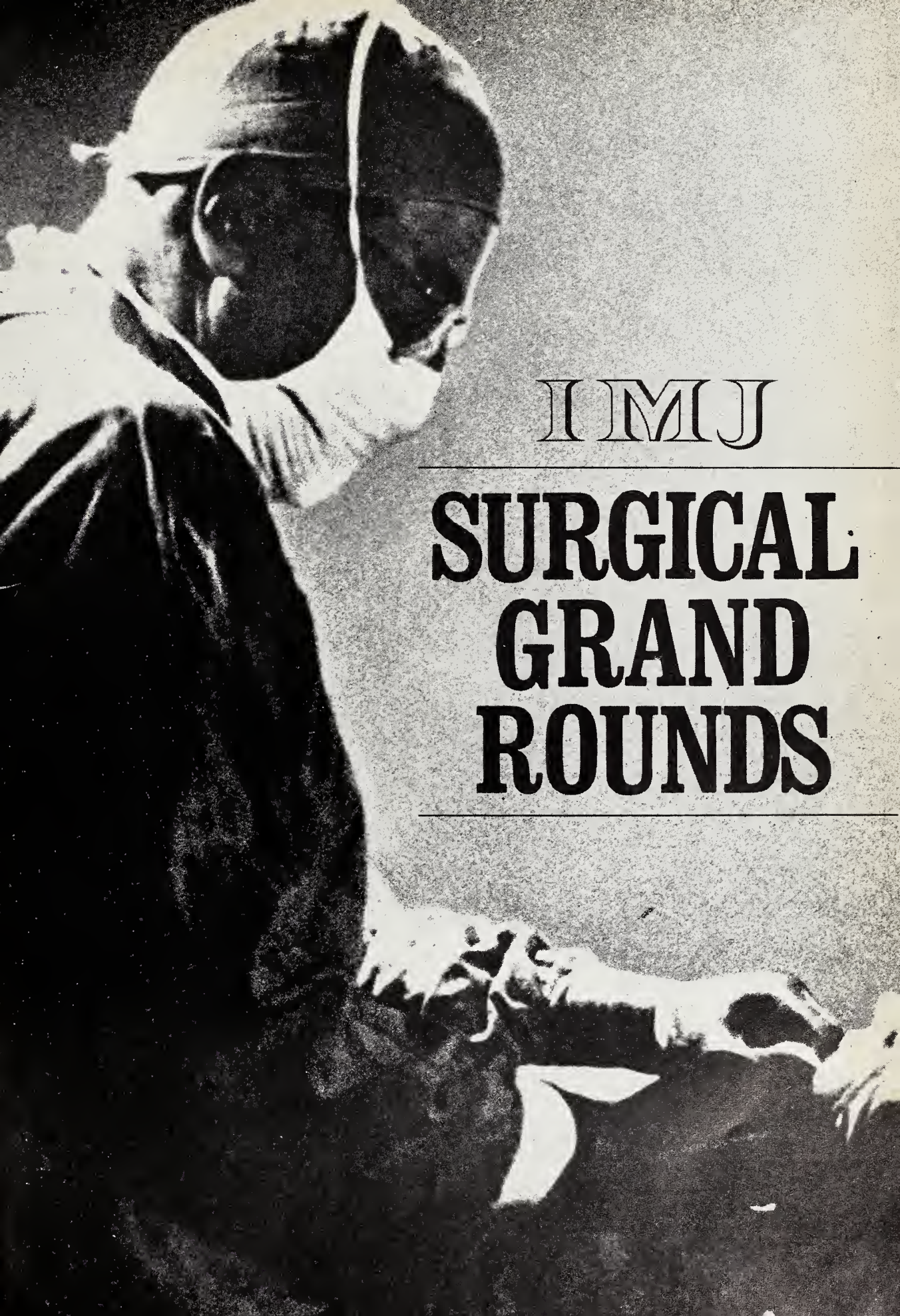
part of the general graduate preparation of maternal and child health specialists.

*The Multiple Handicapped and Mentally Retarded Child.* A 21-month academic and clinical program in planning, organizing, and operating community services for children with multiple handicaps, including mental retardation.

*Career Development Programs.* Three-year academic and residency programs consisting of one year of academic training leading to the degree of Master of Public Health combined with residency training in Pediatrics or Obstetrics-Gynecology.

Applications now being accepted for the group entering in July or September, 1970. For information, write Helen M. Wallace, M.D., School of Public Health, University of California, Berkeley, California 94720.





IMJ

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**SURGICAL  
GRAND  
ROUNDS**

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# Frostbite

EDITED BY JOHN M. BEAL, M.D.

*Surgical Grand Rounds are held weekly on Saturday at 8:00 a.m.; alternating between the Staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds held at Chicago Wesley Memorial Hospital on January 25, 1969.*

## Case Report

**Dr. Arthur Howell:** This 37-year-old male was admitted to V.A. Research Hospital on December 31, 1968, following referral from another hospital. He gives the history of exposure to severe cold for several days before seeking medical treatment elsewhere. He had consumed approximately one-fifth of alcohol daily for a period of about two weeks. He also stated that he had been indulging heavily in alcohol for several years. His past history includes an exploratory thoracotomy with repair of cardiac injury following a stab wound of the chest in 1962 and a gunshot wound of his right foot while in Korea. Physical examination at the time of admission revealed marked swelling of both hands and ears without definite demarcation. Also he presented the findings of early delirium tremens. Chest X-ray revealed a bilateral pneumonitis. Laboratory data was within normal limits. Initial treatment consisted of elevation of the hands with warm moist dressings, antibiotics, and splinting. After approximately two weeks, the frost bitten areas of the digits were sufficiently demarcated to warrant surgical intervention (Fig. 1, 2, 3, 4). The damage was so extensive that the fingers were amputated through the proxi-



**Fig. 1:** The fingers of the left hand have developed dry gangrene.

mal phalanges on both hands. The left thumb was removed at the proximal metacarpophalangeal joint. Approximately half of the proximal phalanx of the right thumb was saved. Both hands were then inserted beneath an abdominal flap.

**Dr. Peter McKinney:** At the present time this patient's debrided phalanges are attached to his abdominal flap so that both hands are immobilized. Some may raise the question of the advisability of tying both hands down. This would not be advisable in an elective situation, but here we had no choice because both hands were involved. He will maintain this position for approximately two weeks before we divide the flaps.

There are different types of cold injury and the extent of the injury depends on two factors: how cold it is and how much wind is blowing. Thus 20° temperature with sufficient wind can be equivalent to zero degree weather, as far as the body surface is concerned. The duration of exposure is very important. We don't know how long this man was exposed, but it must have been some period of time.

Cold injury includes frostbite, immersion foot, and trench foot. These can all occur at temperatures above freezing. Trench foot can be contracted at 50 degrees Fahrenheit if the patient is in a static position and a damp atmosphere. There are some predisposing factors. A healthy, adequately clothed person rarely gets frostbitten. It seldom occurs in sentries, for example. They can be standing quite still, yet they will not develop frostbite, being well clothed and well fed. High altitudes with the resultant hypoxia, starvation, and decrease in calories, and alcohol with decreasing sensation all can predispose to frostbite. It is interesting to note that people who live in cold climates are more resistant to frostbite.

The mechanism of frostbite is interesting because it is the key to treatment. It is basically a disruption in circulation and is associated with the development of intercellular ice crystals. There is a slow freezing between the cell membranes, and ice crystals form, drawing water from the cell to form these crystals. This gives an increased concentration of electrolytes in the cell, which causes a disruption of the cell membrane. Additional damage is then compounded due to resulting cellular hy-



**Fig. 2:** The fingers of the right hand were mummified. Note the length of the right thumb.

poxia to these cells. At very low temperatures, such as that obtained with the use of liquid nitrogen in cryosurgery, intracellular ice crystals develop. This causes irreversible damage.

The circulatory disruption occurs in frostbite because of spasm of the precapillary sphincters, causing an A-V shunt. This spasm is intermittent and brings the blood back to the central part of the body where it is warmed and sent out to the periphery again. However, when the cold blood is circulating at a rate sufficient to lower the body temperature, these sphincters go into spasm and become permanent A-V shunts. In effect nature is sacrificing the limb to save its central portion, that is to maintain body temperature.

The extent of the initial damage is difficult to estimate in frostbite, and this is one of the difficulties in assessing various types of treatment that have been used in the past. The Army has divided frostbite injury into four classifications which are of little practical value because one





**Fig. 3: The appearance of the left hand after debridement is presented.**

cannot tell initially how extensive the injury is. There are certain parameters that are useful and will be mentioned later. It is more practical to classify frostbite as superficial or deep. In a superficial type there may be blister formation and erythema on the back of the hand but with normal circulation in the fingertips and without constricting eschar. This patient had obvious deep cold injury. It should be noted that many have found tendon and bone to be very resistant to a slow freezing injury. This, of course, has been useful to us in tissue banks as we store bones for long periods of time and use it actually as a viable graft after thawing. Skin, muscle, and nerve are very susceptible to injury.

The treatment of cold injury has been confused by a great deal of misunderstanding. Frostbite is not common in most civilian hospitals. In general the first aid treatment of frostbite is to protect the affected part and to prevent further injury. It has been recommended that you should rub snow on the frozen part if you are on a trail. However, note that there is already damaged tissue and that this will cause further damage. You should rest the part and protect it against further insult. It should not be massaged or exercised. The patient should be transported to a warm environment where the proper treatment can be started. There is agreement that a frozen part, if still frozen, should be rewarmed rapidly. This has been demonstrated, both experimentally and clinically, to be of great value. The frozen part is

placed in water at about 40°C for 10-15 minutes to bring it up rapidly to body temperature. If you thaw rapidly, the ice crystals are smaller, the electrolytic shift is less rapid and the resultant damage is much less. Thus, the circulation is restored and hypoxia reversed. The patient is kept in warm environment with his hand or the

injured part in water about 110°F (40°C). Edema is reduced by elevation and immobilization of an extremity so that the patient does not move it and break the skin.

There have been a multitude of treatments given for frostbite. Their multiplicity suggests their ineffectiveness. Among various types of therapy sympathectomy, cortisone, vasodilators, and antihistamines may be mentioned. Low molecular weight dextran has been employed recently to reduce capillary shunting. Remember that the mechanism is basically precapillary sphincter spasm. The best single treatment is to manage these as a burn after the rapid rewarming of the part. Conserve as much tissue as possible without causing further injury and provide early coverage of remaining viable structures. You should provide a new blood supply where blood supply has been destroyed, for example where there has been arterial injury or thrombosis of digital arteries etc. This patient had essentially mummified fingers of all phalanges on both hands. The key to the damage in this patient was the absence of nailbed circulation. It may be hard to assess how deep the damage has been in the finger, but if nailbed circulation is normal there is at least one viable artery which may be enough to allow the bone and tendon to heal. Skin coverage can be accomplished later. However, if you see a patient without nailbed circulation early, it would be better to implant the fingers in pedicle tissue almost immediately. That is, put them under an abdominal flap, leave them there, and raise the pedi-

cle flap around it. By bringing in a new blood supply you can support the bone and tendon so that although he may have an insensitive finger, at least he'll have a finger. This patient was treated late because of his alcoholic situation and delirium tremens. We did not see him until he had a great deal of edema, and we had to wait until this cleared before adequate coverage could be performed. If we had done this earlier, we might have saved more length on his hand.

Now what to do with him? He has pedicles on both fingers of both hands now. We are going to separate these in about two weeks time and he'll be left with a mitt essentially at the knuckle line. On his right hand, and he is right-handed, he has a slightly longer thumb. We plan to deepen this web space so he will have some grasp function.

To summarize the treatment of frostbite and to simplify it, the best early therapy, if the part is still frozen, is a rapid rewarming in a protected environment, elevation to reduce the edema, and if you are not certain of the depth of injury, it is better to wait for demarcation. On a digit, such as a finger, one way to assess the extent of damage is the nailbed circulation. If this is impaired you can save bone and tendon by implantation in an abdominal flap.

**Dr. John Beal:** Dr. Conn, what is the role of sympathectomy in frostbite? This has been a controversial area.

**Dr. Julius Conn:** First, I would like to re-emphasize what Dr. McKinney has said. The basic pathology is an initial injury to the microcirculation. If frostbitten skin is immediately removed it can be used as a free skin graft. The grafted skin will survive so that the early injury must be to the blood supply of the skin and not to



**Fig. 4:** After debridement of the right hand, a useful thumb remained.

the actual cells of the skin.

After thawing of the skin there is intense vasoconstriction with opening of physiological arterio-venous shunts. This constriction produces damage to the capillary epithelium which increases permeability. This leads to the massive edema. Capillary hemoconcentration develops and the red cells tend to aggregate. Within 24 to 36 hours these aggregates go on to completely occlude the capillaries. Cellular death ensues within 48 hours after the capillaries thrombose. The studies on sympathectomy have been somewhat confusing because a few investigators found an increase in the edema and later tissue loss following sympathectomy. Now we know that if the sympathectomy is done within 12 hours of the time of injury there will be increased amount of edema. The edema, however, will subside faster than in the non-sympathectomized limb. There is also less pain, and tissue loss may be somewhat less. However, because of the increased edema there tends to be a decreased blood flow to the area. If sympathectomy is done 24 to 48 hours following injury, which is the time the swelling has reached its peak, there will be rapid resolution of the edema and less tissue loss. This has been proven both experimentally in the laboratory and in series of patients where one upper extremity was sympathectomized and the other was left as the control. On the sym-



pathectomized side there was less tissue loss and less pain. In addition, following sympathectomy patients have less trouble with hyperhydrosis, pain, burning, and tingling of the extremities when exposed to the cold. If sympathectomy is to be done, then it should be done within the first two to three days if it is going to be of value.

The question of Dextran arose in treating this patient also. There has been one well controlled animal experiment using low molecular weight Dextran. It was found that if low molecular weight Dextran was given early it acted very much like sympathectomy. That is, the edema increased but was resolved fairly rapidly with less loss of tissue. The rationale for using Dextran is that flow within the small vessels is increased and intravascular clotting decreased. In comparing Dextran with sympathectomy it has been found that Dextran was not as effective as sympathectomy.

One other thing in the general care that is important to stress is that the patient must have adequate tetanus prophylaxis. This type of wound is also prone to gas gangrene if not handled properly.

**Dr. B. Herold Griffith:** Often frostbite injury is considered to be the same as a deep burn injury. While there are similarities, these are not identical injuries. As Dr. McKinney indicated, it is extremely important to make every effort to save as much length as possible. This can be done only with very early debridement and

surfacing with pedicle tissue, which introduces a new blood supply.

There are other conditions which are similar, from the vascular standpoint, to frostbite. One of them is Raynaud's disease, which of course is not the same as frostbite, but is a vascular problem. We recently presented another patient here with a problem of soft tissue loss in Raynaud's disease, and discussed the advisability of using a pedicle flap to try to preserve length. This was a girl in her late 20's, who had an amputation of a finger of one hand two years ago because of dry gangrene due to Raynaud's disease. Last summer she developed very painful dry gangrene at the tip of a finger of the other hand. We discussed using a flap to preserve length, but since this is an unorthodox treatment for Raynaud's disease, we decided to watch it for a time. It became an excruciatingly painful ulcer, and we finally decided to use a pedicle flap from the chest to introduce new blood supply. This did preserve every millimeter of length. She has excellent function, a very good pad, and a painless finger. This illustrates the fact that you can introduce new blood vessels to a part that has poor blood supply and preserve a great deal of tissue which would otherwise be lost. In an injury such as frostbite, coverage with a pedicle flap certainly should be considered early to preserve the tendons and the bone, which are more resistant to the cold injury than the skin. ◀

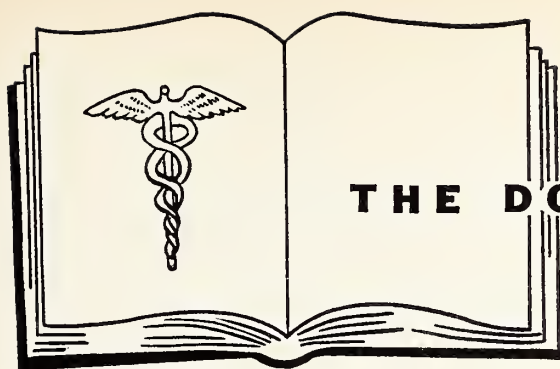
### U. S. Army Wind Chill Index

(Equivalent temperature in cooling power on exposed flesh under calm conditions)

	Temp						
	30	20	10	0	-10	-20	-30
Wind (miles per hour)							
10	16	2	-9	-22	-31	-45	-58
15	11	-6	-18	-33	-45	-60	-70
20	3	-9	-24	-40	-52	-68	-81
25	0	-15	-29	-45	-58	-75	-89
30	-2	-18	-33	-49	-63	-78	-94
35	-4	-20	-35	-52	-67	-83	-98
40	-4	-22	-36	-54	-69	-87	-101

(Wind speeds above 40 mph have little additional chilling effect.)





## THE DOCTOR'S LIBRARY

### CARDIAC FUNCTION IN HEALTH AND DISEASE.

Edited by Robert J. Marshall, M.D. and John T. Shepherd, M.D. 1968. W. B. Saunders Co., West Washington Square, Philadelphia, Pa. 19105. Pp. 409, illus. \$15.00.

Certainly since World War II, the study of the heart in action has sharpened diagnosis, increased therapy and improved the prognosis of patients with heart disease. However, it has also greatly multiplied the requisite skills for the practicing cardiologist. Medical students, residents, and fellows with special interest in cardiology require special guidance to review that complicated development of knowledge. Many physicians with practical experience during this exciting time can also benefit from review of points they may have missed in following the progress of cardiology.

Marshall and Shepherd review the dynamics of cardiac performance in health and disease, briefly and clearly in factual discussion with a minimum of purely technical details. They provide a fundamental basis for applying the results of cardiac catheterization and other dynamic studies to clinical medicine. They introduce the more detailed study of cardiac physiology necessary for serious students interested primarily in basic research. Marshall and Shepherd have covered the field broadly with the exception of electrophysiology and biochemistry, omitted deliberately.

Function of the heart is considered at rest, during exercise, as altered by changes in environment, emotion, metabolic changes, and as damaged by disease. The action of hormones and cardiac glucosides on healthy and on diseased human hearts is considered along with the effects of impaired myocardial circulation, cardiac failure, arrhythmias, valvular deformity, shunts, surgical assault, cardiomyopathy, pericardial disease, and pulmonary disease.

I asked a couple residents in medicine to read *CARDIAC FUNCTION IN HEALTH AND DISEASE* as a training exercise. They found the style easy to read, but the material much more complicated and difficult to master than they had presumed on the basis of their previous casual study. They found the material useful for their own specialty, but thought family physicians with whom they had worked would not use it because there was just too much of it for them to work into their busy schedules.

William H. Wehrmacher, M.D.

**THE SURGICAL MANAGEMENT OF RHEUMATOID ARTHRITIS.** Robert L. Preston, M.D., W. B. Saunders Co., Philadelphia, London, Toronto, 1968, 569 pages.

**THE CARE OF THE RHEUMATOID HAND** Adrian E. Flatt, M.D., C. V. Mosby Co., St. Louis, 1968, Second edition, 222 pages.

The concept of the operative approach in the care of patients with rheumatoid arthritis has generally been considered to be the court of last resort by most treating physicians. These two books represent an attempt by the authors to re-establish the place of orthopedic principles and procedures in the long-term treatment of rheumatoid arthritis.

It is interesting to note that both authors practice in medical centers where the team principle is employed in the treatment of rheumatoid arthritis. Both stress the necessity of early management of patients with rheumatoid arthritis by the team concept. These teams consist of internists, orthopedists and physiatrists, plus ancillary personnel, including physical therapists, vocational counselors, occupational therapists, social workers and laboratory technicians.

Decisions on a plan of treatment are made at a combined conference, utilizing all of the information and knowledge that this varied group can provide.

The book by Dr. Preston is divided into three sections. The first section is on general considerations, and was written by Dr. Currier McEwen, director of the Rheumatic Diseases Study Group of New York University. It includes the pathology of rheumatoid arthritis, the clinical picture and medical management, plus a chapter on juvenile rheumatoid arthritis. Part two deals with general principles of the treatment of musculoskeletal lesions of rheumatoid arthritis, primarily with evaluation and prevention of deformity as well as rehabilitative procedures. Part three, which comprises the major portion of the book, discusses individual joints and reconstructive operations that are available as possible salvage procedures for damaged joints.

The book by Dr. Flatt is limited to care of the rheumatoid hand. The first two chapters deal with the general principles of care and kinesiology. Chapters three and four deal with soft-tissue disease, and include general considerations plus operative treatment. Chapters five and six deal with joint disease, again including general considerations and operative treatment. Chap-

ter seven deals with ulnar drift, chapter eight with the thumb, chapter nine with non-operative treatment and chapter ten the results of surgery.

Two things are of special interest in this book. These are Dr. Flatt's discussion of the use of his joint prosthesis, and, in the tenth chapter, a detailed account of the results of his operative procedures.

Both authors stress the importance of early and adequate synovectomy in the prevention of eventual deformities in patients with rheumatoid arthritis. If patients who failed to respond to a trial of adequate medical management would be referred at an earlier date, the possibility of prevention of many of the serious sequelae and deformities of rheumatoid arthritis could be attainable.

These two books were written primarily for practicing orthopedic surgeons, and, undoubtedly, will be given little attention by other specialists. I feel, however, that they should be found on the desk of every clinician treating patients with rheumatoid arthritis. If the clinician would acquaint himself with the possible procedures available, and would utilize the team approach in the management of his rheumatoid patients, a new day might dawn in the care of this disabling disease.

David C. Bachman, M.D.

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## Film Reviews

"One Door" is the title of a new 28-minute color motion picture about the group practice of medicine. "One Door" illustrates the advantages of group practice such as a single location for comprehensive care, immediate availability of specialists and specialty services, etc. Write: Information Coordinator, Community Health Service, Public Health Service, Room 712-New Post Office Building, 433 West Van Buren St., Chicago, 60607.

\* \* \*

Contraceptive methods are reviewed for hospitalized postpartum women in a film now available through the Planned Parenthood Federation, Inc.

Entitled, "Happy Family Planning," and available in either 16mm. or 8mm. and running for 8 minutes, the film presents its story in graphic devices which are identi-

fied in five languages: English, French, Spanish, Arabic and Chinese.

Designed for showing to lay groups, "Happy Family Planning" can be purchased at cost through Planned Parenthood Federation, 515 Madison Ave., New York, N.Y. 10022.

\* \* \*

"Emergency Ambulance Service: Organization and Operation," is the title of a recent film distributed by the American College of Surgeons.

Produced specifically for the instruction and training of the general public, the film carefully depicts what good emergency ambulance service really is, who runs it, and what some of the organizational and operational problems actually are.

This 24-minute film is available through the ACS Motion Picture Library.

# *Effect of Maternal Virus Infections On The Fetus*

BY ALWIN C. RAMBAR, M.D./HIGHLAND PARK

## **Part II**

### **Mumps**

In 1953, Bowers<sup>70</sup> tabulated the reports of 84 recorded cases of mumps during pregnancy. Of these, nine resulted in abortion or stillbirths, and 12 had congenital defects. He added to these two cases of his own, one mother who delivered a macerated stillbirth, and the other a normal infant. Miller<sup>71</sup> in a special committee study, reviewed 8 cases of maternal mumps with two abnormal infants. The number of cases was too small to draw any specific conclusions. Grönvall and Selander<sup>28</sup> described five malformed infants and one

abortion in 34 cases of maternal mumps. Blattner<sup>21</sup> reported congenital malformations similarly. Manson, Logan, and Loy's<sup>33</sup> report enumerated nine mumps stillbirths and 12 mumps deaths, only three of whose mothers contracted the disease in the last trimester. Congenital anomalies were present in five of the 12 who died, 41.7% compared to 34% of the controls. Ylinen<sup>71a</sup> described a series of 13 cases that developed mumps in the first trimester, only six of whom delivered normal infants.

St. Geme<sup>72</sup> and his associates have attempted to correlate intrauterine mumps infection and primary endocardial fibroelastosis, with special interest in the interpretation of delayed hypersensitivity to inactivated mumps virus antigen. Of 14 patients, 13 were premature versus four in the controls. They could not, however, correlate this test with the presence of mumps virus neutralizing antibody. Their work was not made easier by the possibility that the known serologic interrelationship between mumps virus and the parainfluenza viruses might be expressed as crossreactive cutaneous delayed hypersensitivity. However, they found very few of their EFE patients possessing neutralizing antibodies to parainfluenza viruses. They noted that in 13 infants with EFE, six of the mothers gave a history of exposure to mumps in the first trimester. They found a positive skin test to mumps antigen in 12 of their 13 pa-

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Alwin C. Rambar, M.D., is a Highland Park pediatrician. A Senior Attending Physician in Pediatrics at Highland Park Hospital and Michael Reese Hospital, Chicago, Dr. Rambar is a graduate of the Syracuse University Medical School. He is certified by the American Board of Pediatrics and is a member of the American Academy of Pediatrics.

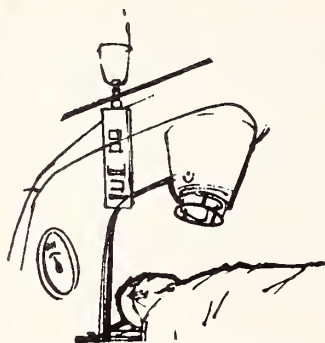


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This is Part II of a two part article by Dr. Rambar. The first installment appeared in the September issue of the *Illinois Medical Journal*.



## Medical Progress



HARVEY KRAVITZ, M.D.  
Medical Progress Editor

tients, contrasted with a positive reaction in only one of 14 infants in their control group. Shone and his group<sup>73</sup> reported that 91% of 50 children with clinical EFE under the age of two years showed a positive reaction to the intradermal inoculation of mumps skin test antigen solution, while 91% of their controls were negative. They also could find no correlation with mumps serum antibody. They consider the possibility that this results from a partial immunologic deficiency whereby the fetus or infant is incapable of developing specific mumps antibodies, but remains capable of exhibiting a delayed cutaneous hypersensitivity response to mumps antigen.

Gersony, Katz, and Nadas<sup>74</sup> in a brief report, studied 16 children who fulfilled the criteria for the diagnosis of EFE. Two cases were proven at autopsy. Investigation by mumps skin antigen and serum assays of mumps HI antibodies showed no relationship between EFE and either mumps specific antibodies or delayed cutaneous hypersensitivity to the mumps virus. They believe that their results are in conflict with others because they required a larger area of erythema (15 mm. as opposed to 10-14 mm.) for their acceptance of positive.

Siegel's<sup>75</sup> prospective study of pregnancies in New York City extending over an 8 year period, shows evidence of an associated increase in early fetal deaths following maternal mumps, especially those occurring in the early stages of gestation. The fetal death rate was maintained at a high level in the third lunar month, as contrasted to rubella. In general, abortions occurred at

a short interval after the onset of the maternal disease. His group postulates that the deaths may not be due to early fetal infection as in rubella, because infection and pathogenicity of the mumps virus in the human fetus have not been demonstrated, nor are they due to severity of the maternal disease, as with influenza or hepatitis. They believe that some other mechanism, possibly normal or placental, is at fault. Over 60% of the fetal deaths in mumps occurred within 14 days after onset of the maternal disease.

### Measles

Measles in the gravid woman may be transmitted to the fetus in utero at any stage in its development. Infants have been born with the typical exanthem, or this has developed during the first few days of life. Measles causes an increased number of abortions and stillbirths. Dyer,<sup>76</sup> in nine of his 24 cases, noted that pregnancy was interrupted by the disease, and 3 of the babies were born with measles. The British Ministry of Health's<sup>33</sup> study of statistics from 99 live-born babies of 103 mothers who had measles during their pregnancy, showed major malformations in seven. The higher rate of malformations, 7% compared with 2% in their controls, was not related to any particular period in the pregnancy in which the infection occurred. Abnormalities noted were of the brain, heart, dislocation of the hip, pyloric stenosis, and corneal opacity. The study concluded that despite the rather high proportion of malformed children in this group, the numbers are too small, and the defects too varied, to suggest an association with the maternal infection. They also found that the infant death rate was particularly high after measles in the first 12 weeks of pregnancy, when six out of the 35 live born infants died before they were two years old. Only one death would be expected in a group this size.

Siegel and Fuerst<sup>77</sup> in their study of the relationship of birth weight to maternal virus disease, found that in measles there was a significant increase in the number of prematurely born infants, and no significant increase in fetal deaths.

Lynch<sup>78</sup> found that, as in smallpox, the result of the pregnancy depended on the severity of the disease and the age of the conception.

## Influenza

Since influenza epidemics and attacks vary greatly in different years, it is difficult to postulate on the effect of this group of viruses on the outcome of pregnancy. Available data<sup>79</sup> from the results of the 1918 pandemic showed that pregnancy was interrupted by stillbirth or abortion in 58% of the pregnancies, and that 50% of deaths from Asian influenza in Minnesota in 1957, in women of child bearing age, occurred in pregnant women.<sup>80</sup>

A review of 663 pregnancies complicated by influenza<sup>81</sup> in the Dublin epidemic of 1957-1958, showed that the incidence of congenital deformities was 2.4 times greater than in a control group. The risk of malformations was said to be the greatest when infection took place in the first trimester. In a follow up study,<sup>82</sup> the ratio was reduced to 1.5; however the CNS abnormalities, *i.e.*, anencephaly, spina bifida, encephalocele, and meningocele had a distinct preponderance in the influenza group.

Hardy's<sup>83</sup> study of the effect of Asian influenza on the outcome of pregnancy when infection occurred in the first trimester, revealed that this virus did indeed appear to exact an unfavorable effect. The incidence of abortion, stillbirth, low birth weight, neonatal morbidity, and congenital malformations was higher when proved infection occurred in the first trimester, as compared to those with infection in the second or third trimester, or with controls from preceding years. On the other hand, Campbell<sup>83a</sup> did not find that influenza in pregnancy added appreciably to the risk of fetal malformations. Hardy,<sup>83</sup> however, believes that the evidence presented is suggestive but not conclusive that there is an adverse effect of influenza infection during the first trimester of pregnancy.

## Poliomyelitis

Pregnant women are known to be more susceptible to poliomyelitis than nonpregnant ones,<sup>84-85</sup> and the death rate has been shown to be almost twice that of the normal disease statistic. Bass and Moloshok<sup>85a</sup> have calculated that almost one third of pregnancies complicated by the acute phase of poliomyelitis result in abortion and fetal or neonatal death. There is evidence that poliomyelitis occurring in the first and

second trimester does retard the infant's development and weight. Poliomyelitis virus has been isolated from the meconium and stools of infants born to mothers with the disease,<sup>86-87</sup> and also found in infants born by caesarean section.<sup>88-89</sup> This offers strong evidence that transplacental transfer of poliomyelitis virus can occur. The route of transmission may also be oral from ingesting infected amniotic fluid. While most observers do not believe that congenital abnormalities result from this disease, Grönvall and Selander<sup>28</sup> reported an increased number of congenital defects.

## Coxsackie Viruses

These viruses are known to have the ability to produce infection in the fetus and newborn. Brown and Evans<sup>93</sup> state that the group B coxsackie viruses can invade the newborn child and cause acute aseptic myocarditis and meningoencephalitis. They made a prospective study for more than six years of the possible association of certain virus infections in the mother with offspring having congenital anomalies, and studied blood samples from pregnant women at the time of their first visit to the obstetrician, usually at the second to fourth month of pregnancy, and again at the time of delivery. Over 9,000 pregnancies were studied and of these, 316 (3.5%) resulted in infants showing some abnormalities. Fifty-three infants (0.58% of the pregnancies) had a diagnosis of congenital heart disease. Data showed that of 43 of the mothers who were studied, 26 had evidence of coxsackie B infection during pregnancy as compared to only 19 mothers of 68 matched controls. They note that this relation of coxsackie virus in mothers of infants with congenital heart disease reinforces the previous information in the literature and adds to the already available data. Gasul<sup>94</sup> noted that acute infectious myocarditis in the newborn is usually due to coxsackie B virus acquired in the uterus, since in many instances there is a preceding history of a mild maternal febrile disease, characterized by malaise, chest pain, and headache.

## Echo Virus

Although epidemics of echo virus are common, there is no report of any increase in malformations resulting from maternal



infection during pregnancy.<sup>59</sup>

### **Hepatitis Virus**

Stokes and co-workers,<sup>95</sup> and Gellis<sup>96</sup> have stated that the virus of homologous serum hepatitis is a likely cause of neonatal hepatitis and that it is transmitted across the placenta by mothers who may be silent carriers of the disease. Zondek and Bromberg<sup>97</sup> reported that in a series of 29 cases, no deformities were noted, but that there was an increased number of premature births. In maternal hepatitis there is an increased fetal mortality, if the disease occurs in the late stages of pregnancy, and is severe in nature. Mansell<sup>98</sup> noted that in a series of 21 cases of hepatitis occurring in the first trimester, three abortions and five infants with congenital anomalies resulted. Grönvall and Selander<sup>28</sup> in 10 cases, found abortion, prematurity, and one abnormal infant resulting when the disease occurred in the first trimester. Siegel's<sup>75</sup> excellent prospective study shows a definitely increased fetal mortality rate after maternal hepatitis, especially in the last trimester. Roth<sup>99</sup> noted that in 16 cases occurring throughout all stages of pregnancy, two abortions, three stillbirths, and 11 normal children resulted. Kass<sup>100</sup> delivered an infant with hydrocephalus and microphthalmia whose mother had the disease in the first trimester, and Hellbrugge<sup>101</sup> described a similar case. An increased incidence of Downs syndrome after a hepatitis epidemic has been reported.<sup>102</sup>

The data so far is not conclusive as to the danger of this virus to the conceptus, and to date no controlled studies are available.

### **Western Equine Encephalitis**

There is highly suggestive evidence that at least one of the Arbor viruses, the agent of western equine encephalitis, may be transmitted to the fetus during the viremic stage of the disease. Symptoms attributed to this virus occurring in the mother shortly before delivery have been followed in several instances by disease in the infant, during the first week of life.<sup>102a</sup>

### **Infectious Mononucleosis**

The American Academy of Pediatrics special committee reports<sup>103</sup> in 1949, listed only five instances of infectious mononucleosis during pregnancy, all of which oc-

curred in the first trimester. Two of the five infants were normal and three were abnormal, one having a congenital heart defect, and the other two had cataracts. This report is too limited for conclusions as to teratogenicity resulting from this disease.

### **Cytomegalovirus**

Cytomegalovirus infections are frequent in pregnancy, and are usually mild in nature. It is believed that 30% to 80% of all women in the child bearing age period have had infections prior to their pregnancy.<sup>11</sup> The diagnosis of this disease is rarely made, as the only manifestation may be mild respiratory disease or subclinical liver involvement.<sup>104</sup> Sever<sup>105</sup> believes that 6% of pregnant women may have a CMV infection. It is known that this disease does occur in utero and that the fetus, if infected, and the mother have the same strain of virus. The mother's disease may be inapparent, but the baby's disease is manifested by jaundice, hepatosplenomegaly, thrombocytopenic purpura, pneumonitis, and meningoencephalitis. Those who survive may have microcephaly, intracranial calcifications, severe mental retardation, convulsions, incoordination, and deafness. The infected infants may recover from the hematologic, hepatic, and pulmonic involvements, but be left with CNS sequelae. It is Hanshaw's<sup>106</sup> opinion that the preschool child with perceptual difficulties, behavior problems, deafness, and specific learning difficulties, could conceivably have been exposed to gestational influences without overt disease in the mother, or clinically diagnosable disease in the neonatal period. He has shown that cytomegalic inclusion disease (CID) is relatively common, and in a study<sup>107</sup> of sera from 41 infants with microcephally, 44% were positive for CMV. Medearis<sup>11</sup> proved that these infants, as in those with congenital rubella infections, support the multiplication of virus and excrete large quantities of it.

Rubella virus affects the fetus most severely when the maternal infection is in the first trimester. CMV on the other hand, presumably affects the fetus most after the fifth month of pregnancy. Hanshaw<sup>108</sup> believes that there may be a transfer of virus to the fetus at most stages of pregnancy, but the relationship of congenital infec-



tions to abnormalities remains in doubt, so that infection in the first trimester is not clearly a known fact. The infants with microcephaly at birth are probably infected in the second trimester, while those infants who are normocephalic at birth but later have a failure of head growth, are probably infected in the third trimester.

Hanshaw<sup>106</sup> recommends that since this virus is so prevalent, patients on immunosuppressive therapy, and infants suspected of having an intrauterine produced infection, should not be attended by expectant mothers. He further believes that until further data are available, it is recommended that CMV infection be considered as potentially dangerous to the developing fetus as rubella. Medearis<sup>11</sup> states that there is no effective means for treating or preventing human CMV infections. This disease, as in rubella, is mild in pregnancy, and it would indeed be fortunate if all prospective mothers had the infection prior to their pregnancies.

### Summary

An unknown percentage of fetal abnormalities are caused by maternal virus infections. Apgar and Stickle<sup>109</sup> state that abnormal conditions of congenital origin are a leading cause of death and disability in the United States, and that an estimated 500,000 fetal deaths and at least 62,000 neonatal deaths are associated with birth defects each year. They further estimate that there are 15,000,000 persons with one or more congenital defects in this country.

Much of the voluminous information available on the effects of virus infection in pregnancy is based on epidemics of past eras, and also on single or small series of case reports, attempting to equate abnormalities with an obstetrical illness. If enough specific abnormalities occurred after maternal infections which could satisfy statistical standards as measured against controls, valuable information could become available. Actually there are only a limited number of reports that are valid. There is also some evidence that viruses in certain years may be more deleterious to the pregnancy than in others, which further disrupts comparative figures.

Maternal virus infection appears to increase the possibility of abortion, stillbirth, and a reduction in the size of the infant

at birth. Statistics show that maternal rubella, hepatitis, and mumps increase the possibility of fetal deaths. In influenza and hepatitis there is an increase in fetal deaths, especially if the disease is severe and occurs late in pregnancy. In contrast, there is an increase in fetal deaths in rubella and mumps, when the maternal infection occurs early.

There is adequate proof that rubella in the first trimester of pregnancy, and cytomegaly viruses in the later stages of pregnancy, are teratogenic and cause a variety of malformations. Maternal coxsackie B infections appear to increase the incidence of congenital heart disease. While the viral hypothesis as a cause of fetal abnormalities is attractive, except in the case of rubella and CID, it is so far unproven. Large series of amniocentesis studies will improve our knowledge, but the small series so far reported are inadequate to draw definitive conclusions.

It is wise to immunize the population against those diseases that we have specific vaccines for, and in the female before she becomes pregnant.<sup>110</sup> The use of live virus vaccines, especially rubella and smallpox, should be avoided during pregnancy. Pregnancy should be avoided for at least two months after inoculation with rubella vaccine.

Unfortunately, in the only other proven viral teratogen, the cytomegaloviruses, there is no treatment of any value in preventing the serious results that may occur after maternal infection. Although steroids have been used in the treatment of infants with cytomegalic inclusion disease,<sup>111</sup> it does not appear that this could have any beneficial effect on an infant who already has motor and mental retardation from his maternal infection. ◀

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## *Clinics for Crippled Children Scheduled*

Twenty-two clinics for Illinois' physically handicapped children have been scheduled for December by the University of Illinois, Division of Services for Crippled Children. The Division will conduct fifteen general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing service. There will be five special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- Dec. 2—Belleville—St. Elizabeth's Hospital
- Dec. 3—Alton Rheumatic Fever & Cardiac —Alton Memorial Hospital
- Dec. 3—Rock Island Cerebral Palsy—3808 Eighth Avenue
- Dec. 3—Hinsdale—Hinsdale Sanitarium
- Dec. 3—Carmi—Carmi Township Hospital
- Dec. 4—Lake County Cardiac—Victory Memorial Hospital
- Dec. 4—Effingham General—St. Anthony Memorial Hospital
- Dec. 9—East St. Louis—Christian Welfare Hospital

- Dec. 9—Peoria General—Children's Hospital
- Dec. 10—Champaign-Urbana — McKinley Hospital
- Dec. 11—Litchfield—Madison Park School
- Dec. 11—Springfield General—St. John's Hospital
- Dec. 12—Chicago Heights Cardiac—St. James Hospital
- Dec. 12—Evanston—St. Francis Hospital
- Dec. 17—Springfield Cerebral Palsy—Diocesan Center
- Dec. 17—Aurora—Copley Memorial Hospital
- Dec. 17—Chicago Heights General—St. James Hospital
- Dec. 18—Elmhurst Cardiac—Memorial Hospital of DuPage County
- Dec. 18—Bloomington—St. Joseph's Hospital
- Dec. 18—Rockford — Rockford Memorial Hospital
- Dec. 19—Chicago Heights Cardiac — St. James Hospital
- Dec. 23—Peoria General—Children's Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.





## Membership Forum

Dear Sir:

Thank you so much for your very interesting piece in the July issue of the *Illinois Medical Journal*. You brought together a lot of interesting points and reviewed some history for me that was getting pretty dim in my memory. I enjoyed it immensely.

Kind regards,  
James H. Hutton, M.D.  
Past President, ISMS

Dear Sir:

We wish to compliment the Illinois State Medical Society for your efforts in an attempt to draw more students into the medical profession.

Sincerely,  
Kankakee County Medical Society  
Herbert P. Swartz, M.D.  
Secretary-Treasurer

Dear Sirs:

The American Board of Family Practice announces that it will give its FIRST examination for certification in various centers throughout the United States. The examination will be over a two-day period on February 28-March 1, 1970. Information regarding the examination and eligibility for the examination can be obtained by writing:

Nicholas J. Pisacano, M.D.,  
Secretary-Treasurer  
American Board of Family Practice, Inc.  
University of Kentucky Medical Center  
Annex #2, Room 229  
Lexington, Kentucky 40506  
Thank you,  
Nicholas J. Pisacano, M.D.  
Secretary-Treasurer

*Ed. note: Membership Forum is a means for the ISMS physician to express opinion and viewpoint on varied topics. If you have an item you would like brought before your fellow practitioners, please submit it to Membership Forum, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601. Communications should not exceed 250 words. The right to abstract or edit is reserved. Names will be withheld upon request, but anonymous letters will not be accepted.*

'Thank you America!'

Permit me, a Canadian, to express a long overdue "thank you America"—not only for putting men on the moon, but for almost 200 years of contributing to the betterment of mankind. For the airplane, radio, cotton gin, phonograph, elevator, movie machine, typewriter, polio vaccine, safety razor, ball-point pen and zipper!

No other land in all the world has, in so brief a history, contributed so much and asked so little—only that we live together in peace and freedom.

From the days of Washington and Lincoln, you have demonstrated the creativity, invention and progress of free men living in a free society—where ideas and aspirations may be promoted to the extent of man's willingness to work and build a "better mousetrap" with commensurate rewards.

Thank you for upholding the principles and rights of freedom and liberty; for the American Constitution and Bill of Rights and for protecting those rights even when it results in the burning of your flag and the murder of your President.

Thank you for those who helped defend freedom on foreign soil in two world wars—a debt we have been able to pay in small measure by way of some 10,000 Canadian volunteers who stand and fight with you in Vietnam; for the foreign aid you give even when your hand is bitten and your motives impugned; for keeping your dignity in the face of insults from nations still wet behind the ears; for your patience with those who seek to steal the world and enslave its people; for keeping your cool even when the Trojan horse mounts the steps of the White House to insolently spew forth its treason.

Thank you for keeping alive the concept of individual liberty and faith in God in a world wallowing in humanistic collectivism.

For these reasons and so much more, I say: "Thank you America and God bless you."

Patricia Young  
Vancouver, B.C.

(from Dr. P. Thomsen, Reprinted from the Chicago "Sun-Times")

# SOCIO ECONOMIC *news*

*A service of the Public Relations and Economics Division*

By JOSEPH J. LOTHARIUS

## **State Peer Review Conference Scheduled**

ISMS Board members approved a request from the Council on Economics and Governmental Health Agencies to hold a statewide peer review conference in February. District and county prepayment plans committees as well as county medical society officers will be invited to attend with representatives from commercial insurance carriers, Blue Cross-Blue Shield, and IDPA. The purpose of the proposed one-day session will be to activate an effective peer review mechanism throughout the state that can be adaptable to fit all peer review requests. The seminar will be held as part of the annual ISMS Leadership Conference.

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## **IDPA Reports High MD Participation**

A record number of physicians—8,040—are treating Illinois public aid patients as of June, 1969, according to Harold E. Swank, IDPA director. Mr. Swank told the ISMS Board of Trustees that 5,700 of the above physicians have signed IDPA agreements. Letters have been sent to the others requesting them to sign agreement forms. Of the 8,040 participating doctors, 1,203 are from out-of-state (Indiana, Wisconsin, Missouri and Kentucky), 3,012 are from Cook county and 3,825 from downstate. From Jan. 1, 1967 through June, 1969, physicians have been paid 90.4%—\$29,147,838—of their \$32,251,285 billings to IDPA for public aid patients under 65. (Excludes payments for services to Medicare-Medicaid patients).

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## **Six Percent IDPA Appropriation Increase**

Harold E. Swank told ISMS board members that IDPA received a 6% increase last July in its appropriation for physicians' services for the 1969-70 biennium. As of July 1, 1969 the additional money has been applied to increased physician payments in two general areas:

1. Increased payments to doctors for those procedures in which IDPA had been paying lower than average percentage of the charges. At least 10% of the participating physicians have already benefited from these increased payments, according to Mr. Swank.

2. Increased payments to doctors who raised their fees between Jan. 1, 1967 and Jan. 1, 1969.

## State Schools Graduate 541 MDs in 1969

Illinois' five medical schools produced 541 doctors in 1969. This included 188 from the University of Illinois; 138 from Northwestern University; 85 from Stritch Medical School; 68 from Chicago Medical School, and 62 from the University of Chicago. The ISMS Task Force on Physician Shortage is studying ways to keep the majority of these graduates in Illinois. Presently, about 60% of those physicians educated in the state are leaving after graduation to practice elsewhere.

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## Medicaid Abuses In Sheltered Care Homes

Look for IDPA to reject MD claims for NON-ACUTE medical care in a sheltered care home not having nursing facilities in which the billing physician has a financial interest. IDPA will also reject payment of mileage claims of these physicians when traveling to and from their facility.

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### YOUR ISMS INSURANCE QUESTIONS

**QUESTION:** What limits of liability are available under the ISMS Plan?

**ANSWER:** Limits of \$1,000,000 and higher are available covering personal and Professional Liability.

*Do you have a question of general interest on any ISMS-sponsored insurance program: Retirement Investment, Keogh, Group Disability, Group Major Medical, Professional Liability (Malpractice)? Send it to this column: "Your ISMS Insurance Questions," Illinois Medical Journal, 360 N. Michigan Avenue, Chicago, Ill. 60601. The column is a service of the ISMS Committee on Medical Economics and Insurance.*

### Eight Ways Suggested To Avoid Malpractice Suits

Malpractice actions constitute a definite occupational hazard for the doctor, according to the magazine **Massachusetts Physician**. With the help of the law department of one of the underwriters of professional liability coverage, the publication offers this advice for staying clear of suits:

- ▶ Do not disclose the fact that you carry professional liability insurance.
- ▶ Do not admit responsibility for any injury.
- ▶ Report to your insurance company remarks made by any physician concerning your services.
- ▶ Retain complete records of contacts with your patients, including entries of telephone conversations.
- ▶ Require pre- and postprocedure X-rays in cases involving foreign bodies, fractures, and dislocations. X-rays are your property and should be kept with your other records.
- ▶ Avoid filing suits for collection of fees until counter claims alleging negligence are barred by the statute of limitations.
- ▶ Report to your insurance company immediately after any unusual occurrence, accident, or mistake in your practice and before attending an inquest in any case that may give rise to a claim against you.
- ▶ Consult your insurance company before making a statement concerning your services if a claim is filed or anticipated.

"Medical World News," Sept. 12, 1969





# Doctor, What Does Your Medical Assistant Do For You?

By MRS. RUBY JACKSON/CHICAGO

## DOES SHE:

- Answer the telephone?
- Schedule appointments?
- Take x-rays?
- Perform laboratory tests?
- Assist you during examinations and treatments?
- Collect fees?
- Order supplies?
- Do the typing, filing, bookkeeping, etc.?
- Fill out insurance forms?

Your medical assistant may do all or only part of the above or any combination of duties. She may have had formal training to do these duties or you may have trained her in your own way; but, after one year as a member of the Illinois Medical Assistants Association, she will be a better medical assistant to you, making your work easier and your office run smoother.

By attending Illinois Medical Assistants Association meetings and symposia and by reading the I.M.A.A. publications, she will learn newer, more efficient methods of operation which have been time tested in other offices. She will become acquainted with other medical assistants and hear lectures by informed people which will result

in greater on-the-job competence. This will in effect be a post-graduate education as well as an opportunity for her to enjoy group insurance benefits, low-cost vacation trips and greater professional status.

Many doctors feel that an I.M.A.A. membership given to their medical assistant is a form of extra bonus or benefit to her and, as it is tax deductible, a good bargain.

After you, Doctor, your medical assistant is the most important person in your office. Frequently the patient sees more of your medical assistant than she does of you and, therefore, she must be qualified to handle her share of duties as a part of the medical team.

So if you have a medical assistant doing any of the tasks mentioned above, as a bonus give her an I.M.A.A. membership for one year. At the end of that time evaluate her progress and improvement, which will be evidenced by better management of your office and a more efficient medical assistant.

For more information, please contact either Mrs. Vivian Johnson, First Vice-President, 9105 S. Albany, Evergreen Park, Illinois 60642, or Mrs. Mary Siers, Second Vice-President, 801 North 84th Street, East St. Louis, Illinois 62203. ◀

## ***Looking for a Place to Practice? Placement Service Lists Openings***

In an effort to reduce the number of towns in Illinois needing practicing physicians, the *Journal* is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

**WABASH COUNTY:** Mt. Carmel; population: 10,000. Seven physicians. Wabash General Hospital. Housing and office space available. Agriculture, industry and oil producing area. Fifteen Protestant and Catholic churches. Grade and high schools. Forty miles from Evansville, Ind., population 150,000. Nearby college. For further information contact: C. L. Johns, M.D., Secretary, Wabash County Medical Society, 114 W. 5th, Mt. Carmel; Phone: 262-4513.

**WARREN & MERCER COUNTIES:** Alexis; population: 1,000. Several small towns in trade area without physicians. Only physician died recently at age 53. Nearest hospitals at Monmouth and Aledo, 15 and 18 miles. Forty miles to Quad cities. Attractive office recently remodeled and refurnished, large reception room, 4 examining rooms, lab-pharmacy and business office. Financial assistance if desired. Agricultural area. Many commuters to quad cities. Catholic and Protestant churches. Grade and high schools. Six golf courses within 15 minutes. Five miles to Lake Warren. Excellent financial opportunity. For further information contact: W. R. Hunter, M.D., Alexis; Phone: 482-3466 or 482-3962.

**WASHINGTON COUNTY:** Nashville; population: 3,000. Four physicians until recently. Town has only one physician, age 61. Urgent need for 2 physicians. Trade area: 14,000. One physician retired. One died. Four dentists. Washington County Hospital located here. Opened 5 years ago.

Fifty miles southeast of St. Louis. Two drug stores. Predominant nationalities; German and Polish. Agriculture and industry. Protestant and Catholic churches. Catholic and Lutheran schools. Recreational facilities: city park, swimming pool, newly constructed municipal golf course. Hospital completely equipped; fully accredited. Financial assistance available. For further information contact: T. Janssen, Hosp. Adm., Nashville.

**WAYNE COUNTY:** Fairfield; population: 6,400. Trade area: 20,000. Six active physicians. Fairfield Memorial Hospital and Wayfair Nursing Home; 94 beds; open staff. Seventy miles from Evansville, Ind. Two prescription stores. Office facilities include 4 ground floor locations. Sources of income: agriculture, oil and industry. Twenty Protestant and Catholic churches. Grade and high schools. Exceptional recreational facilities. For further information contact: Charles Jannings, M.D., Fairfield Medical Center, Fairfield.

**WHITE COUNTY:** Crossville; population: 1,000 Trade area: 2,500. Only physician died in 1961. Nearest physicians at Grayville, 8 miles, and Carmi 7 miles. Nearest hospital at Carmi, 57 beds. Thirty miles from Evansville, Ind. Office space and housing can be arranged. Financial assistance if desired. Sources of income: agriculture and oil. Churches: Southern Baptist, Primitive Baptist, Methodist and Church of Christ. Grade and high schools. Country Club and pool 8 miles. Thirty unit housing project completed in 1965. For further information contact: M. T. Richards, W. F. Sanders, or James Westfall, Crossville.

**WHITESIDE COUNTY:** Prophetstown; population: 2,000. Trade area: 6,000. Only 1 physician, age 62. Second physician left to specialize. Eleven miles to nearest hospital at Morrison. Thirty miles to Moline, population, 50,000. One prescription store. Local committee would build if facilities a problem. Space in business district. Financial assistance available. Six Protestant and Catholic churches. Grade and high schools. Local golf course. All-weather swimming pool. Medical society advises that physician who left had very busy practice. For further information contact: C. W. Schuneman, or S. E. Robinson, M.D., Prophetstown. Phone: 815-537-2301.



## —THE VIEW BOX—

(Continued from page 572)

**Diagnosis:** Pulmonary embolism with infarction.

We are beginning to appreciate the incidence of pulmonary embolism with infarction as various authors report it to be as high as 50% in postmortem material. The common etiologies which must be kept in mind are 1) post trauma, 2) post surgical (particularly pelvic surgery), 3) abortion, 4) post partum, 5) venous stasis, 6) previous heart disease, 7) birth control pharmaceuticals, 8) pancreatitis, and many other lesser causes.

Pulmonary embolism with infarction is usually tolerated without great disability, although survival may be jeopardized if further emboli occur. About 80% of patients fall within this category. Clots are virtually almost always multiple and distributed to both lungs, particularly at the lung bases. Only 10 to 15% will cause definite infarction. The normal lung may become infarcted as previous pulmonary disease is not a necessary factor in the development of infarction. About 60% of patients have some radiographic pulmonary abnormality within 24 hours of the apparent time of embolization, and it frequently occurs within a few hours of the episode. Typically the area of infarction is homogeneously dense and lies against the pleural surface. Its margins are not discrete. It may initially increase in extent and subsequently it almost always regresses, partially by 7 days and completely by 20 days except for a small residual of

one type or another. Infarcts may be multiple and visible in both lungs. About 50% will develop evidence of pleural effusion within the first 24 hours. The pleural effusion is usually directly continuous with the pulmonary opacity and frequently is located in the costophrenic angle, the so-called "Hampton's hump." The pleural effusion usually clears simultaneously with the pulmonary infarction. The restriction of respiration and increased broncho constriction is probably responsible for the elevation of the hemidiaphragm. The main pulmonary artery may be dilated as an initial response. This is difficult to evaluate, particularly if there have not been any preceding films. The arterial dilatation may be the result of a shower of small emboli or may be due to the mass of the embolus itself, accounting for the so-called "plump hilum." This will usually disappear within a few days. The least common sign of embolus is diminution of the calibre of the arteries peripheral to the embolus and is very difficult to assess. This patient recovered uneventfully on anticoagulants during her course. She had an elevated L.D.H. and the isotope scan confirmed the presence of nonvisualized infarcts in the left lung. ◀

### Reference

"Radiographic Aspects of Pulmonary Embolism," by Melvin M. Figley, M.D., Arthur J. Gerdes, M.D., and Howard J. Ricketts, M.D., *SEMINARS IN ROENTGENOLOGY*, Vol. 2 (4), October, 1967.

### JCAH Hospital Field Tests

As a result of an action of the Board of Commissioners at their August 9, 1969 meeting, the Joint Commission is expanding the field testing of new survey questionnaires that are being developed to determine compliance with the revised standards.

Several hospitals in the state of Illinois will be asked to participate in one of two field tests. The first test is being conducted as part of the routine accreditation survey procedure. A hospital is sent one section of the proposed questionnaire and is asked to complete it in addition to the usual survey form. During his accreditation visit, the surveyor reviews the test questionnaire and returns it with his and the hospital's comments, to the Joint Commission research department.

The second test involves selected hospitals completing the entire proposed questionnaire (12 sections). On a pre-arranged date, a member of the research department will visit the hospital and review the questionnaires with those members of the hospitals and medical staffs involved in completing the questionnaire.



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**Composition:** Each tablet contains potassium bicarbonate (2.5 Gm.), citric acid (2.1 Gm.), cyclamic acid, artificial flavor and color. **Contraindications:** When renal function is impaired, or if the patient has Addison's disease, potassium supplementation should not ordinarily be instituted. **Precautions:** Should not be used in patients

with low urinary output unless under the supervision of a physician. In established hypokalemia, attention should be directed toward correction of frequently associated hypochloremic alkalosis and other potential electrolyte disturbances. Patients should be directed to dissolve tablet in stated amount of water to assure against gastrointestinal injury associated with the oral ingestion of concentrated potassium salt preparations. **Side Effects:** While nausea has been reported in an occasional patient, K-Lyte produces no serious side effects when given in recommended doses to patients with normal renal function and urinary output. Potassium intoxication causes listlessness, mental confusion, tingling of the extremities and other symptoms associated with a high concentration of potassium in the serum. **Administration and Dosage:** K-Lyte effervescent tablets must be dissolved in 3 to 4 ounces of water before taking. Adults: 1 tablet 2 to 4 times daily, depending on the requirements of the patient. Two tablets (50 mEq. of elemental potassium) supply the approximate normal adult daily requirement. **How Supplied:** Effervescent tablets — boxes of 30 (orange or lime).

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LABORATORIES

# Cardiac Catheterization, Positive Blood Cultures And Antibiotic Prophylaxis\*

BY WILBUR FRANKLIN,\*\* M.D., PHILIP Y. PATERSON, M.D.  
AND SHELDON H. STEINER, M.D./CHICAGO

The precise incidence of bacteremia and bacterial endocarditis resulting from cardiac catheterization is unknown. Hence, the relative merits of antibiotics to prevent bacterial endocarditis following this procedure is unclear. The American Heart Association<sup>1</sup> has recommended prophylactic antibiotics in conjunction with cardiac catheterization but indicated that because of lack of definitive data, many cardiologists feel such prophylaxis is unwarranted.

Recently and while the study here described was still in progress, Gould and Lyon<sup>2</sup> reported that adults undergoing cardiac catheterization occasionally may develop fever and infrequently may yield positive blood cultures. Kreidberg and Chernoff<sup>3</sup> had previously made similar observations in infants and children. In both

studies, no direct relationship between positive blood cultures and development of fever was observed, implying that bacteremia and febrile episodes are independent consequences of cardiac catheterization. Of more pointed interest, prophylactic antibiotics did not materially reduce either the incidence of bacteremia or the occurrence of fever.

The present study provides additional information concerning the question of bacteremia during cardiac catheterization and further supports the view that routine antibiotic prophylaxis is not essential in connection with this procedure.

## Methods

The cardiac diagnoses for the 25 patients in the study here reported were as follows: 15-rheumatic valvular heart disease; 1-congenital aortic stenosis and aortic regurgitation; 1-congenital pulmonary stenosis; 1-congenital pulmonary stenosis with atrial septal defect; 1-congenital aortic insufficiency with ventricular septal defect; 1-idiopathic cardiomyopathy; 2-idiopathic hypertension (no demonstrable heart disease); 2-no cardiac disease and 1-organic heart disease of unknown etiology. Age of patients ranged from 16 to 64, average age being 44. Nine were males; 16 were females.

Three blood cultures were drawn from most patients. The first sample was drawn prior to starting the catheterization procedure by routine venepuncture using a



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Northwestern University Medical Center. In addition, he is director of the Samuel J. Sackett Research Laboratories. Dr. Paterson is a member of the American Heart Association Committee on Prevention of Rheumatic Fever and Bacterial Endocarditis. Sheldon H. Steiner, M.D. (not pictured), is a Chicago cardiologist, and formerly Director, Cardiovascular Laboratory, Chicago Wesley Memorial Hospital. He received his M.D. degree from Duke University and is certified by the American Board of Internal Medicine. Wilbur Franklin, M.D. (right) is a resident in pathology at Chicago Wesley Memorial Hospital. He is a graduate of the University of Chicago and received his M.D. degree from Northwestern University Medical School.

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Table 1

ve blood cultures associated with cardiac catheterization

Penicillin	Number of Patients	Proportion Of Patients With Positive Blood Cultures
Penicillin	4	1/4
Penicillin	21	4/21

vein in the antecubital fossa after preparing the site with an antibacterial sudsing emulsion† and tincture of benzalkonium chloride.†† The second sample was obtained through the cardiac catheter 5 to 30 minutes (15-20 minutes in most cases) after the catheter was inserted into the vein. This second sample was drawn with the catheter tip situated in the right innominate vein, superior vena cava, right atrium or the pulmonary arterial vasculature. The third sample of blood was also collected via the cardiac catheter and was taken just before termination of the procedure, i.e., 1½ to 4 hours after insertion of the catheter.

A 5 ml. aliquot of each blood sample was injected into each of two blood culture bottles containing 100 ml. trypticase soy broth□ or beef brain-heart° infusion broth. Room air was allowed to pass through a cotton stoppered needle into one of the 2 bottles to provide an aerobic environment. Air was not added to the other bottle which provided an anaerobic environment. All culture bottles were incubated at 37° C. and subcultured onto sheep blood agar plates and thioglycollate broth 3 days and 21 days after inoculation with blood. The subcultures were incubated for 48 hours at 37° C., the blood agar plates being in plastic bags containing a mixture of 10% carbon dioxide and room air.

For various reasons, four patients had received penicillin within the month prior to cardiac catheterization. Two patients received oral penicillin up to one day before catheterization and a third until 4 days before the procedure. A fourth was receiving continuous penicillin prophylaxis in the form of monthly benzathine penicillin

injections to prevent recurrent streptococcal infection. Penicillinase (50,000 units)\* was added to culture bottles inoculated with blood samples from these patients. Procaine penicillin G (600,000 units b.i.d. for 3 days) was administered intramuscularly in all patients beginning immediately after completion of cardiac catheterization.

### Results

A total of 54 blood cultures from 20 of the 25 patients gave no evidence of bacterial growth. Six of the 13 blood cultures from the remaining 5 patients were positive. As shown in Table 1, the proportion of patients with positive cultures was not influenced by prior antibiotic administration. One-fifth of patients had positive cultures, irrespective of whether they had received penicillin for anti-streptococcal prophylaxis or other reasons prior to cardiac catheterization. None of the 25 patients developed fever or other clinical evidence of infection in association with the catheterization procedure.

Details concerning the positive blood cultures from the 5 patients are presented in Table 2. Positive cultures were obtained from individual patients at different times in reference to cardiac catheterization, including one sample (patient number 21) drawn before the procedure was started. Except for the diphtheroid isolated from patient number 10, the 5 bacterial isolates from the remaining 4 patients were identical and presumably represented a single bacterial species. The apparent clustering of 4 of the 6 isolates from 3 patients studied consecutively (patient numbers 19, 20 and 21) is of interest but probably fortuitous.

The bacterial isolates from patients number 14, 19-21 had these characteristics in common. Each was a gram positive, spore forming rod, growing only under strictly aerobic conditions. The inability of these isolates to grow under markedly reduced oxygen tension was demonstrated as follows. Isolates from patients 19, 20 and 21 were grown overnight in 10 ml. of trypticase soy broth to give turbid suspensions containing from 95 to 177 x 10<sup>6</sup> organisms per ml. by standard plate count. The turbid suspensions were diluted with trypticase soy broth to 10<sup>-4</sup>, 10<sup>-5</sup> and 10<sup>-6</sup>. One ml. of each of these 3 dilutions was inoculated into a brain-heart infusion culture bottle. No air was admitted into the cul-

† pHisoHex (Winthrop Laboratories, New York, New York)

†† Zephiran Chloride (Winthrop Laboratories, New York, New York)

□ Becton, Dickinson and Company, Rutherford, New Jersey.

○ Difco Laboratories, Detroit, Michigan.

Table 2

Positive blood culture data from individual patients undergoing cardiac catheterization

Time Blood Samples Drawn For Culture Relative To Catheterization	Blood Culture Results From Patient*				
	No. 10	No. 14	No. 19	No. 20	No. 21
10 minutes before	Neg	Neg	Not Done	Neg	<u>POS</u>
10 to 30 minutes after	Neg	Neg	<u>POS</u>	Neg	<u>POS</u>
2 hours or more after	<u>POS</u>	<u>POS</u>	Not Done	<u>POS</u>	Neg

\* The microorganism from patient No. 10 was isolated from the aerobic culture bottle by subculturing after 21 days incubation and was identified as a diphtheroid. Each of the other 5 bacterial isolates proved to be a gram positive spore-forming *Bacillus* isolated from the aerobic culture bottle after 3 days incubation.

ture bottle to assure relatively anaerobic conditions. After 3 days and 21 days of incubation at 37° C, the inoculated bottles were subcultured onto blood agar plates and plate counts made after 18 hours of additional incubation at 37° C. None of the culture bottles yielded any evidence of bacterial growth.

Each of the 5 isolates produced no hemolysis on sheep blood agar, fermented any of 9 routine sugars, produced acid or gas on triple sugar iron agar or gave a positive Voges-Proskauer reaction or positive methyl red test. Four of the 5 isolates tested by routine disc methods were sensitive to a variety of commonly used antibiotics but resistant to kanamycin. Based on these results, each isolate was classified as a *Bacillus* species.

### Discussion

At least three lines of evidence suggest that the few bacterial isolates were not indicative of bacteremia *per se*. (a) Five of the 6 isolates had a sufficient number of characteristics in common to classify each as a *Bacillus* sp. One of these 5 isolates was cultivated from blood obtained *prior* to beginning the catheterization procedure. (b) The bacteria isolated (*Bacillus* sp.) were not those considered most representative of the skin flora and likely to cause bacteremia in association with manipulation and break in the cutaneous barrier. (c) Finally, the "clustering" of isolations of the *Bacillus* sp. from patients numbers 19, 20, and 21 suggests that this organism may have been introduced into the culture bottles in the processing of blood culture samples. Careful review of all methods and check of disposable materials and equipment used failed to reveal any apparent break in techniques. There was no evidence pointing toward contamination of either the disposable tubings or catheterization equipment.☆ The available evidence favors

the view that the diphtheroid and *Bacillus* sp. isolates represented environmental commensals which inadvertently gained access to the blood culture media.

Kreidberg and Chernoff<sup>3</sup> observed positive blood cultures in 5% of 452 pediatric patients undergoing cardiac catheterization, irrespective of whether penicillin was or was not given prophylactically. Of the bacteria isolated from the culture samples, almost one-half were *Staphylococcus albus* and *Staphylococcus aureus*. The remaining organisms were of a heterogeneous pattern and included *Gaffkya* species, *alcaligenes* and aerobic spore forming rods. Gould and Lyon<sup>2</sup> in their study of 114 adult patients observed positive cultures in 17% of patients receiving prophylactic penicillin and 18% of those not so treated. *Pseudomonads* and other (difficult to classify) gram negative rods were isolated from both the antibiotic treated as well as control group of patients and may well have accounted for the higher percentage of positive blood cultures observed, in contrast to the report of Kreidberg and Chernoff.<sup>3</sup> Our finding of positive blood cultures in one fifth of our group of adult patients, none receiving antibiotic prophylaxis specifically for cardiac catheterization, is similar to the incidence of positive cultures observed by Gould and Lyon.<sup>2</sup> Furthermore, isolates from our adult patients more nearly mirror those described by Gould and Lyon than the gram positive micrococcal isolates from children reported by Kreidberg and Chernoff.<sup>3</sup>

☆ Cardiac catheters and all other equipment routinely used in the catheterization procedure were sterilized by soaking in Detergicide (United States Catheter and Instrument Corporation, Glens Falls, N.Y.)—44% N-alkyl dimethyl benzyl ammonium chloride; 56% aqueous acetyl phenoxy polyethoxy ethanol—for 2-4 hours, rinsing in distilled water four times, soaking in distilled water for approximately one hour and autoclaving for 15 minutes.

(Continued on page 622)

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## Cardiac Catheterization

(Continued from page 620)

Occurrence of bacteremia due to pathogenic microorganisms in association with catheterization of the heart is a rare event. It would seem prudent to conduct cardiac catheterization using strict aseptic technique without antibiotic prophylaxis and to follow the patient carefully during the immediate post-catheterization period. Should fever occur, suitable blood cultures could be obtained and antibiotic therapy instituted. This is a more selective approach to the problem than the all-inclusive one represented by routine antibiotic prophylaxis. This more selective approach would also be consistent with the established failure of routine antibiotic prophylaxis to "prevent all types of infections" when this procedure has been critically assessed in other situations, e.g., post-operative wound infections, pneumonia in the unconscious patient and infection following routine bladder catheterization.<sup>4-6</sup>

### Summary

Bacteremia due to pathogenic microor-

ganisms in association with cardiac catheterization is a rare event. This conclusion is based on results of 67 blood cultures from 25 patients undergoing cardiac catheterization without prophylactic antibiotics. Our observations further support the view that routine antibiotic prophylaxis is not essential in connection with diagnostic catheterization of the heart. ◀

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## Exponential Growth

Dr. Frederick Moore, quoted by Eugene A. Stead, Jr., M.D., in August, 1969 issue of **Resident and Staff Physician**:

"A favorite example of exponential growth is the boy who contracted on this 18th birthday to work for the U. S. Government for 1 cent the first year, with the guarantee of a 100% raise each year until retirement at age 65. He worked until he was 38 years old for less than \$5250 a year, and in all those 20 years of work the sum total of his wages was only about \$10,500. However, after only 5 more years, his income leaped to over \$150,000 a year, and on his 45th birthday he started earning \$1,340,000 a year. At age 54 he began to earn well over \$1 billion, and the last year before his glorious retirement he was scheduled to pocket the gross national product. During all that time his wage in any one year equalled the sum of his earnings in all the prior years.

"It is apparent that this constant rate of exponential growth (I.E., doubling each year) yielded a 20-year period in which the absolute income each year was so small as to be almost disregarded and the absolute increases from year to year were so small as to be disregarded also. Then followed a period of only 8 years in which wages shot up by astonishing amounts from 'almost poor' to 'more than rich'. Before his scheduled retirement it would have become impossible to pay his wages because doing so would destroy the source of payment."





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**Contraindications:** Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

**Warning:** Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

**Adverse Reactions:** Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence.

As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported.

Symptomatic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others.

Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported.

Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia.

A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

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## *Drug Safety Tip for the Home*

Concerned that many families may not be following safe practices in storing and using drugs, outlined below are several basic suggestions for improved home drug safety.

Many drugs and medicines lose their potency in time and may even become dangerous. Buying and storing them in large amounts could invite trouble, and it is urged that the date purchased be written on the label of all non-prescription drugs.

It is emphasized that medicines and drugs should always be kept away from children and it is strongly recommended that all such items be stored out of their reach, even under lock and key if necessary. It is important to keep drugs in original containers. This practice prevents a drug from being mistaken for another medicine which may resemble it. If a label should come off, stick it on with transparent tape and don't rely on color, type of bottle, shape of pill, etc., for identification.

When giving and taking medicines, keep your mind on what you are doing. Do not use medicine in an unlabeled container or medicine whose label cannot be clearly read and do not try to use a drug in the dark. Satisfy yourself every time that you

have the medicine and the dosage prescribed by the doctor and that you know directions for use before you take or administer it.

We would also like to warn against the practice of using medicine prescribed for one person on another without first consulting a physician.

Every medicine cabinet should be inspected and old, outdated drugs be thrown out, especially those prescribed for specific illnesses or conditions which have been cured. Drugs may be disposed of by flushing them down the toilet, but in no case should they be put into the trash. Also, empty drug containers should not be discarded where inquisitive children or pets can get into them.

People are urged to check their home drug safety habits now and regularly in the future. Questions about storing, handling and disposing of drugs can be answered by the prescribing physician, a registered pharmacist, the local Poison Control Center or hospital emergency room, and by your health department. With the safety of all in mind, we will cooperate in every way with our citizens in helping them establish safe drug-use practices in their homes.

(From Illinois Department of Public Health.)

## *Brochure Discusses Pain*

"There is only one pain that is easy to bear and that is the pain of others."

Opening with that statement by the French surgeon René Leriche, a new brochure, *PAIN*, explores the nature of pain and man's attempts through the ages to endure it, cure it, explain it, and, at times, to use it for his own purposes.

Issued by the National Institute of General Medical Sciences, a component of the National Institutes of Health, the brochure explains why pain, a universal experience, defies universal definition.

Among subjects considered in the brochure are:

The two concepts of pain: a necessary warning or a disease in itself?

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# Surgical

## Management Of Parkinsonism

BY HAROLD C. VORIS, M.D., PH.D./CHICAGO

The purpose of this paper is the evaluation of the role of surgery in the treatment of Parkinsonism. The concept of surgical treatment of abnormal movement is not new but its current widespread application to Parkinsonism can be said to date from 1953 when Cooper<sup>1,2</sup> noted relief of tremor and rigidity in the contra-lateral extremities of a patient in whom the anterior choroidal artery was accidentally torn during the course of an operation. Credit for the first neurosurgical attempt to relieve abnormal movements belongs to Sir Victor Horsley<sup>4</sup> who in 1909 resected a portion of the precentral gyrus in a patient with severe athetoid movements in the contra-lateral arm. Following this, cortical ablations were performed sporadically for various hyperkinetic syndromes, including severe Parkinsonian tremor. The resultant spasticity, weakness and tendency to epileptiform seizures made the operation inapplicable to all but the severest cases. Section of the motor pathways in the spinal cord (cordotomy) received some attention but on the whole the results were less encouraging than with cortical ablation. The same proved true of pedunculotomy; that is, section of the cerebral peduncle at the midbrain level.

Meyers<sup>5,6</sup> in 1939 began to carry out operations on the so-called basal ganglia and associated structures. Although these operations carried a high morbidity and mortality risk, they did demonstrate that it was possible to alleviate tremor and decrease rigidity without producing weakness, spasticity, hyper-reflexia and disturbances in gait.

### Attempts at Instrumentation

After World War II attempts to develop a human stereotactic instrument began. The first such instrument was described by Spiegel, Wycis, Marks and Lee<sup>7</sup> in 1947. The obvious clinical application of human stereotaxy was to the tremor and rigidity of Parkinsonism and the thousands of stereotactic procedures that have been performed in the past twenty years have been in the main directed at the alleviation of that condition.

### Etiology

The location of the causative lesions of Parkinsonism and the etiology of the disease remains in doubt. Various specific locations of the disease process have been advanced. However, no location has been postulated, for which examples of severe involvement without clinical symptoms do not exist. Conversely no series of cases of Parkinson's disease have been reported in

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which a single anatomical area was always involved. This leads to the conclusion that Parkinson's disease is a diffuse irregular involvement of a complex and highly integrated system of motor control.

There is equal uncertainty about the etiology of this condition. The original description of this syndrome by Parkinson in 1817 was likely of a condition due to a degenerative process. The encephalitis epidemics of 1917-1920 were followed by a Parkinsonian-like syndrome but there were prominent vegetative disturbances, and rigidity and hypokinesia were present to a previously unnoted degree.

A few writers have been so impressed with the post-encephalitic origin of the disease that they have predicted it would disappear after the death of all persons born before 1930. Current observations on the appearance of the disease do not support this concept.

### **Basic Physiologic Mechanisms**

Our understanding of the basic physiologic mechanisms involved in the production of the symptoms is understandably unsatisfactory in view of the foregoing gaps in our knowledge. Fortunately, the clinical recognition of the condition is easy in most cases; so much so that the physician's secretary or office nurse will generally recognize the diagnosis as she ushers the patient into the consultation room. The characteristic facies, the shuffling gait, the tremulous voice, and the lack of spontaneous movement separates these patients from their fellows. The normal individual frequently changes his position when sitting or standing, only the Parkinsonian patient can remain immobile for a considerable length of time. When sitting the patient with Parkinsonism keeps his feet close under the chair all the time. The normal person pulls his feet in when getting up from the chair, stretches them out after sitting down and repeats this each time he sits.

The handwriting is generally affected early. It becomes smaller and angular without the normal curve or rounding of the letters. This symptom, of course, is most valuable when the dominant hand is initially involved.

Weakness of eye convergence is another early sign. The patient may complain of difficulty in lighting a cigarette or cigar

because he cannot focus his eyes so close in front of him. Finally, one of the earliest symptoms is seldom volunteered but is readily admitted on questioning, namely, that the patient needs no blanket at night.

At one time the principal findings in Parkinsonism were thought to be tremor and rigidity plus an irregularly present variety of symptoms such as excessive secretion of the sebaceous glands, oculogyric crises, forced yawning, intractable blepharospasm, dysarthria, drooling of saliva, exaggerated laughing or crying, and impairment of balance. All of this is still true, but the importance of a third manifestation known as akinesia or bradykinesia (slowing of voluntary or willed movements) became apparent when it was noted that some patients that had been operated on had, in fact, lost their rigidity without functional improvement in their activity. It is now realized that many of the so-called associated symptoms of the disease are manifestations of this bradykinesia.

### **Medical Management**

I do not propose to discuss medical management in detail. To date there has been little improvement in our armamentarium since the introduction of stromonium. True, the development of various synthetic modifications of the organic belladonna preparations and the addition of amphetamines and the phenothiazine drugs has increased our armamentarium to the point of confusion, but has not improved its quality.

It is very important to recognize the development of undesirable side effects and not push medication to the point of mental confusion, incontinence, etc. At the same time, as in other chronic diseases, the patient who is being treated does better on the whole than the untreated patient—which is another way of saying that the psychological value of treatment is important.

The obvious shortcomings of medical treatment have led to continuing attempts to treat disorders of movement, especially Parkinsonism by surgery. We have already referred to the development of the present surgical techniques and can now consider the details of present day surgery for Parkinsonism.

### **Surgery**

Most important is the selection of pa-



tients. It can be categorically said that surgery is useless in patients who are already invalids or are mentally deteriorated. Candidates for operation must be ambulatory, preferably under 60 and not over 70 years of age. Ideally they should be working so that a successful result means their return to gainful employment. Practically, a return to work cannot be expected in many cases because of mandatory age retirement rules, the reluctance of many employers to employ elderly workers with chronic disease, and because pension plus social security benefits often equals or nearly equals the wage that can be earned. A most important factor in the success of treatment is motivation. Lack of motivation will usually be verbally denied by the patient and often not recognized or glossed over by the relatives.

Tremor is the manifestation of the disease that is usually most benefitted by surgery. A satisfactory operative procedure will remove or at least greatly alleviate tremor. Rigidity is usually greatly relieved. Hypokinesia is the most difficult manifestation to improve by operation although on occasion an operation may help much more than is anticipated. Unfortunately, the weak faltering voice, the disturbances in gait, the stiff or rigid posture, and the so-called vegetative symptoms are often unimproved by surgery and—with relief of tremor and rigidity in the extremities—may appear more marked than before operation. Severe impairment of balance is not helped by operation and may be made worse. This worsening may again be apparent rather than real since improvement of tremor and rigidity may leave poor balance as the chief obstacle to satisfactory ambulation.

A great number of stereotactic devices are available to the surgeon. These range from simple guiding devices for the surgeon's hand to elaborate mechanisms that can be repositioned on the patient's head at any future time in exactly the same way as initially used. Some can be easily held in the palm of the hand. Others are so massive as to require special support for the floor on which they stand.

Variation in skulls makes it impossible to rely on landmarks in the plain roentgenogram of the skull. Visualization of the third ventricle and its neighboring structures is necessary. This can be done with various contrast media including air. Cur-

rently we use Heimburger's<sup>3</sup> method of a mixture of 2 cc. of 60 per cent Conray with 8 cc. of cerebrospinal fluid or normal saline. The landmark used as a reference point should be as close to the desired target as possible. This minimizes distortion due to magnification of the X-ray and errors in measurements.

The details of calculations of the target and the setting of the instrument depend on the apparatus used. A number of targets have been used and each has its proponents. The differences in terminology of thalamic and mesencephalic structures as well as the variations in the landmarks favored by various authors make the comparison of the targets of various surgeons difficult, if not impossible. Finally, the variations of the nuclear masses as described in various atlases compound difficulty. Consequently, physiological localization by stimulation, the recording of spontaneous electrical activity and of evoked potentials is essential.

Stimulation may increase the tremor and this indicates a satisfactory target although the cessation of tremor, as the electrode or probe is introduced to the target, is an even better indication of a satisfactory localization for the lesion. The most important use of stimulation is to avoid placing the lesion too close to the internal capsule. If motor responses are obtained at low parameters of stimulation the movement of the electrode to a different area is necessary.

The functional mapping of the thalamic nuclei by the records of their spontaneous electrical activity has been under way in a number of neurosurgical centers. It is time consuming and requires considerable experience and careful standardization of equipment. However, it will be the basis for eventual construction of functional or physiological maps of the thalamus.

The recording of the evoked potentials that may be obtained by stimulation of various afferent nerves is often used for more rapid identification of the desired target. The usual points of stimulation are the median nerve at the wrist or the sural nerve in the leg, but others may be used.

### **Technics**

It is obvious from the foregoing that these procedures should be carried out under local anesthesia and without any medication that will of itself lessen or stop



tremor or interfere with electrical stimulation or recording. Fortunately we have in visteril (atarax) a drug which has a marked quieting effect, does not inhibit tremor or interfere with the electrical activity of the nerve cell and thus makes it possible to carry out prolonged procedures without undue discomfort.

The lesions themselves have been made by injection techniques, electrocoagulation, leukotomes, radiation or ultrasound and cold (freezing). Initially injections were used, but the irregularity and irreproducibility of the results were soon apparent. Some skilled operators favor the leukotome, but the blind use of a cutting instrument deep in the brain has such obvious danger that most operators prefer something else. Radiation or ultrasound both have the distinct theoretical advantage of not requiring the passage of a tube, probe or electrode into the brain with possible resultant damage. However, these methods require expensive instrumentation and elaborate techniques of administration.

The use of freezing techniques has been popularized. This promises to be of considerable benefit in other areas of neurosurgery, especially in the removal of certain tumors. However, the following criticisms can be made of its use for thalamic lesions. The apparatus is expensive, the smallest probe available is larger than one needed for heating techniques and the lesions tend to be hemorrhagic with the resultant risks of later extension beyond the desired bounds.

On the whole, the method of tissue destruction by heating seems the safest and best controlled, especially when carried out by temperature control from a thermocouple built into the probe. This permits controlled heating for a desired length of time to a desired level, thus avoiding burning or charring of tissue and controlling the size of the lesion. The condition of the patient can be monitored during the production of the lesion. This can be halted if undesirable effects develop.

At the present time small controlled lesions can be made stereotactically in the thalamus or midbrain of properly selected patients under 70 years of age without significant risk. The mortality should be nil and the morbidity low. Certain lesions because of their location may carry the risk of complication of motor weakness or disturb-

ance of conjugate eye movements, but this does not apply to the lesions currently used for the treatment of tremor or rigidity. Unduly large or multiple lesions may cause temporary mental confusion. Occasionally, disturbances in balance result from thalamic surgery—this seems more apt to occur if there is previous disturbance in this sphere. Early ambulation and prompt resumption of activity is important, as the bedridden Parkinsonian patient is usually prone to respiratory complications.

Patients who have a significant component of bradykinesia may be considerably benefitted by rehabilitation therapy. In fact, a good physiotherapy department can often greatly enhance the results of surgical intervention. Aside from a possible postoperative period for treatment in the rehabilitation department, the sooner the patient is returned to his home and normal activity the better the result will be.

### Conclusion

In conclusion stereotactic surgery can be of value in properly selected cases of Parkinsonism. The results will depend on the proper selection of cases and the utilization of adjunct medical and physical therapy. Patients and their families should understand that surgery, like other forms of treatment in this condition, is symptomatic and not curative and that its effects are generally more or less selective, helping tremor and rigidity more than some of the other manifestations of the disease. ◀

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# public affairs library reviews

THE LAW, Frederic Bastiat, The Foundation for Economic Education, 1968

**The Law**, to many who are interested in political affairs and government is often used as the text of basic principles of fact and is stored on a handy bookshelf in the office and in the home for convenient, repeated reference.

The author Frederic Bastiat, (1801-1850) was a French economist, statesman and author. He did most of his writing during the year just before and immediately following the revolution of February, 1848.

This was a period in France not unlike the current period in the United States when the country was turning rapidly toward increased government control, higher taxation and the resulting loss of individual liberty.

As a Deputy to the Legislative Assembly, Mr. Bastiat studied and explained each socialist fallacy as it appeared. He explained how socialism must inevitably degenerate into communism. Of course, most of his countrymen chose to ignore this logic. Today communism is a powerful political force in France.

The translation of **The Law** was done by Dean Russell of the staff of the Foundation for Economic Education, Irvington on the Hudson, New York. His objective was an accurate rendering of Mr. Bastiat's words and ideas into 20th century english. The book is now in its eighth printing since the first translation and well over 500,000 copies have been sold.

Bastiat presents an uncanny forwarning of the results of abuses of law and order. In the chapter entitled "Property and Plunder," he said:

"Man can live and satisfy his wants only by ceaseless labor; by the ceaseless application of his faculties to natural resources. This process is the origin of property.

"But it is also true that a man may live and satisfy his wants by seizing and consuming the products of the

labor of others. This process is the origin of plunder.

"Now since man is naturally inclined to avoid pain—and since labor is pain in itself—it follows that men will resort to plunder whenever plunder is easier than work. History shows this quite clearly.

"When, then, does plunder stop? It stops when it becomes more painful and more dangerous than labor.

"It is evident, then, that the proper purpose of law is to use the power of its collective force to stop this fatal tendency to plunder instead of to work. All the measures of the law should protect property and punish plunder."

This writing is typical of his thoughts throughout the book which cause one to thoughtfully consider the situation in the United States today.

Bastiat maintains that law is justice and it is only under the law of justice, under the reign of right, under the influence of liberty, safety, stability and responsibility that every person will attain his real worth and the real dignity of his being.

In his final chapter he recommends that we try liberty and that we do away with the quacks and organizers. That the artificial systems be discarded along with the whims of governmental administrators, their projects, their centralization, their tariffs, and their pious moralizations.

Regardless of your opinion on how our central government should be operated, its limitations or its powers, **The Law** provides a unique opportunity for a stimulating review of basic principles. The explanations and arguments then advanced against centralism and its adverse effects on the citizenry are—word for word—equally valid today.

Noted for its basic simplicity and easy reading, the book totals only 76 pages. Hard cover edition \$1.75, soft cover \$1.00.



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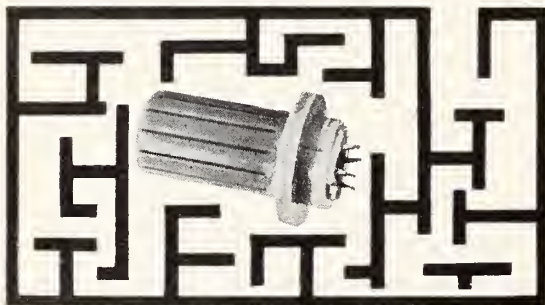
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## President's Page

(Continued from page 558)

That's a mere \$10 on \$10,000 assessed valuation. In many counties the tax-levy is less.

I ask every county medical society to endorse the health department concept. I ask medical society members to take an active role in making the concept a reality. Such things as forming a physician speaker's bureau to get your neighbors interested is a good place to start. Bring this subject up at county medical society meetings, urge your colleagues to join you in this important cause.

I can assure you the full cooperation of the Illinois State Medical Society to help you in your planning. The Illinois Department of Public Health is also most willing to cooperate. I'm told the Department has a team available to travel into any county to help establish a public health department structure.

Let's work together to erase the present statistic revealing one third of our people don't enjoy adequate public health protection. This is an advantage that should be available to everyone.

*Edward W. Camady*

"Before the Emergency," is the title of a new award winning 28-minute film which tells the story of inadequate and injurious care and treatment of accident victims due to the unpreparedness of most American communities.

Selected as the "safety film of the year" by the National Committee on Films for Safety in Washington, D.C., it is available by writing: Modern Talking Pictures Corp., 1909 Prudential Plaza, Chicago 60601.

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by Paul deHaen

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**New Dosage Forms:** Of a previously introduced product.

A New Drug Application has been granted by the U.S. Food and Drug Administration for the following new drug, but its marketing date has not been announced.

**ACHOLEST** Detection of decreased Cholinesterase activity

**Nonproprietary Name:** Cholinesterase Test-Paper  
**Manufacturer:** Fougere

The following new drugs have been marketed:

### NEW SINGLE CHEMICALS

**ARISTOSPAN** Anti-inflammatory Agent  $\mathcal{R}$   
**Manufacturer:** Lederle

**Nonproprietary Name:** Triamcinolone Hexacetonide

**Indications:** Rheumatoid arthritis and osteoarthritis

**Contraindications:** Do not give intravenously. TB, herpes simplex, psychosis, hypersensitivity to components, peptic ulcer, glomerulonephritis, MG, osteoporosis, intestinal anatomoses, diverticulitis, thrombophlebitis, diabetes mellitus, hyperthyroidism, coronary artery disease, infections and pregnancy.

**Dosage:** 2-20 mg. (0.1 cc to 1.0 cc)

**Supplied:** Vials—5 cc

**MATULANE** Cancer chemotherapy  $\mathcal{R}$

**Manufacturer:** Roche Laboratories

**Nonproprietary Name:** Procarbazine HCl (US-AN) (BP) Ibenzmethyzin

**Indications:** Palliative management of Hodgkin's disease

**Contraindications:** Hypersensitivity to the drug  
Inadequate marrow reserve

**Dosage:** 50-300 mg. daily

**Supplied:** Capsules—50 mg., bottles of 100

### COMBINATION PRODUCTS

**EUTHROID** Thyroid preparation  $\mathcal{R}$

**Manufacturer:** Warner-Chilcott

**Composition:** By weight:

4 parts sodium levothyroxine

1 part sodium liothyronine

**Indications:** Thyroid replacement therapy

**Contraindications:** Acute myocardial infarctions.  
Abnormalities of adrenal function.

**Dosage:** Individualized

**Supplied:** Bottles of 100 tablets.

4 potencies available.

**FLUOGEN** Biological  $\mathcal{R}$

**Manufacturer:** Parke, Davis

**Composition:** Each 0.5 cc contains

400 CCA units extracted immunizing antigen type A<sub>2</sub>/Aichi/2/68 (Hong Kong variant)

300 CCA units extracted immunizing antigen of B/Mass./3/66"

**Indications:** Immunization against influenza

**Contraindications:** Sensitivity to eggs, chicken, chicken feathers or dander; acute respiratory disease or other infection. Defer use in epidemic of poliomyelitis unless influenza a greater threat.

**Dosage** Individualized injection

**Supplied:** Rubber-diaphragm-capped vial—5 cc

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**HISTAMINE** Cough Preparation o-t-c

**Manufacturer:** Fellows-Testagar

**Composition:** Syrup, Each 5cc contains:

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Ephedrine Sulphate 10 mg.

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Alcohol 2 %

**Indications:** Symptomatic relief of coughs due to colds or allergies—especially where increasing fluidity of respiratory secretions is desired.

**Contraindications:** High blood pressure, heart disease, diabetes or thyroid disease.

**Dosage:** Over 12 yr.: 1 tsp. every 3-4 hrs.

Children: 6-12 yrs.: 1/2-1 tsp. every 3-4 hrs.

3-6 yrs.: 1/4 tsp. every 4-6 hrs.

1-3 yrs.: 10-14 drops every 4-6 hrs.

**Supplied:** Cherry-flavored syrup.

**INFLUENZA VIRUS VACCINE** Biological  $\mathcal{R}$

**Manufacturer:** Wyeth

**Composition:** Each 1 cc contains:

400 CCA units extracted immunizing antigen type A<sub>2</sub>/Aichi/2/68 (Hong Kong variant)

300 CCA units extracted immunizing antigen of B/Mass./3/66 strain

**Indications:** Immunizations against influenza

**Contraindications:** Sensitivity to eggs, chicken or chicken feathers

**Dosage:** Individualized injection

**Supplied:** Vials—10 cc and 1 cc

**MANDALAY A.P.** Antibacterial-urinary  $\mathcal{R}$

**Manufacturer:** Beutlich

**Composition:** Methenamine Mandelate 500 mg.

Phenazopyridine HCl 50 mg.

**Indications:** Urinary tract infections arising from gram negative and gram positive organisms.

**Contraindications:** Impairment of liver function or renal insufficiency.

**Dosage:** Children over 6: 1 tablet every 6 hrs.  
Adults: 1-2 tablets every 6 hrs.

**Supplied:** Bottles of 100 dual-release 550 mg. tablets.

**MUCROZYME** Enzyme  $\mathcal{R}$

**Manufacturer:** Fellows-Testagar

**Composition:** Autolyzed proteolytic enzymes

**Indications:** Non-traumatic and non-mechanical pain of inflammatory nature.

**Contraindications:** Hyperallergenic patients. Do not inject intravenously.

**Dosage:** Single dose 1.3 cc i.m.

**Supplied:** Ampules—1.3 cc

**ZONOMUNE** Biological  $\mathcal{R}$

**Manufacturer:** Lilly

**Composition:** Each 0.5 cc contains:

400 CCA units of A<sub>2</sub>/Aichi/2/68 (Hong Kong variant)

300 CCA units of B/Mass./66

**Indications:** Immunization against influenza

**Contraindications:** Acute respiratory disease or active infection. Egg sensitivity.

**Dosage:** Individualized injection

**Supplied:** Vials—2.5 cc

(Continued on page 636)

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## Meeting Memos

**Nov. 19-23—The Academy of Psychosomatic Medicine**

*16th Annual Meeting*

Mountain Shadows, Scottsdale Arizona

"Psychiatry in the Daily Practice of Medicine"

**Nov. 21-22—The Institute of Medicine of Chicago**

*Delivery of Medical Care in the 1970's*

Ambassador Hotel, Chicago

**Nov. 30—American Medical Association Dept. of Health Education**

*National Conference on the Medical Aspects of Sports*

Cosmopolitan Hotel, Denver, Colorado

**Nov. 30-Dec. 3—American Medical Association**

*Clinical Convention*

Denver, Colorado

**Nov. 30-Dec. 3—American Academy for Cerebral Palsy**

Caesar's Palace

Las Vegas, Nevada

**Nov. 30-Dec. 5—Radiological Society of North America**

Palmer House, Chicago

**Dec. 4-5—University of Iowa**

*Continuing Education Conferences*

University of Iowa, Iowa City, Iowa

"Cardiac and Respiratory Disease"

"Obstetrics and Gynecology"

**Dec. 4-6—American Rheumatism Association**

*Interim Meeting*

Pioneer Hotel, Tucson, Arizona

**Dec. 5—Chicago Surgical Society**

*Scientific Program*

University Club of Chicago

76 East Monroe Street, Chicago

**Dec. 7-9—American Society of Hematology**

Sheraton Hotel

Cleveland, Ohio

**Dec. 6-11—American Academy of Dermatology**

Americana Hotel

Bal Harbour, Florida

**Dec. 10—Frontiers of Medicine—1969-1970**

*Trauma*

University of Chicago, Hospital & Clinics

950 East 59th Street, Chicago

**Dec. 10-11—The Cleveland Clinic Educational Foundation**

*Ophthalmic Postgraduate Course*

2020 E. 93rd St., Cleveland, Ohio

"Concepts in Diagnosis and Management

of Diseases of Vitreous, Retina and Choroid"

**Dec. 12-14—American Psychoanalytic Association**

Waldorf Astoria Hotel

New York City, N.Y.

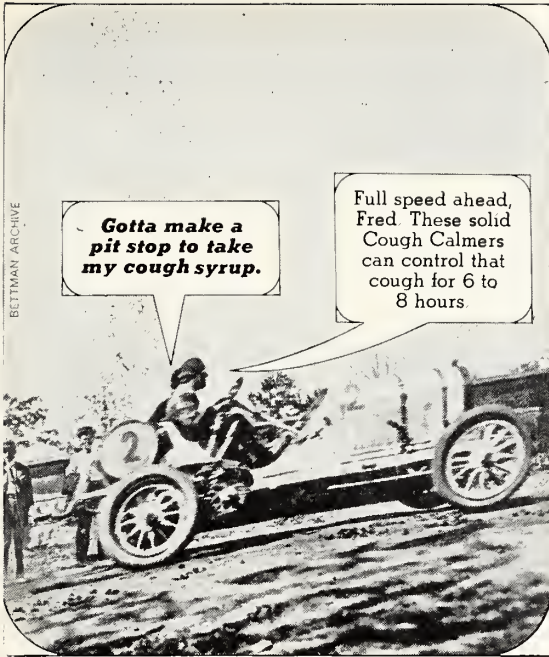
**Dec. 19-20—University of Kentucky College of Medicine**

*Practical Ophthalmology for the Generalist*

Albert B. Chandler Medical Center

University of Kentucky, Lexington, Ky.





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URISED is safe . . . especially useful in long-term management of chronic cases; as a prophylactic measure with catheterization or after instrumentation. No systemic reactions or bacterial resistance have been reported.

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Each blue-coated tablet contains active:

Atropine Sulfate .03 mg.	Methylene Blue . . . 5.4 mg.
Hyoscyamine . . . 0.03 mg.	Phenyl Salicylate .18.1 mg.
Methenamine . . . 40.8 mg.	Benzoic Acid . . . . 4.5 mg.

**PRECAUTIONS:** Administer with caution to persons with known idiosyncrasy to atropine or cardiac disease. While under this therapy the urine is blue; patients should be so advised to allay apprehension.

**SIDE EFFECTS:** Neither irritation nor other untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occur, decrease dosage. If rapid pulse, dizziness, or blurring of vision occur, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

**CONTRAINDICATIONS:** Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

**DOSAGE:** Adults—Two tablets, orally, four times per day followed by liberal fluid intake. Acute cases—Initially two tablets every hour for three doses followed by the recommended daily administration. Children—One-half the adult dose.

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PHARMACEUTICALS, INC.  
CHICAGO, ILLINOIS 60640

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OF URICEUTICAL®  
SPECIALTIES

## New Pharmaceutical Specialties

(Continued from page 633)

### NEW DOSAGE FORMS

**AMCILL Synthetic Penicillin**

R

**Manufacturer:** Parke, Davis

**Nonproprietary Name:** Ampicillin trihydrate

**Indications:** Urinary, respiratory and gastrointestinal tract infections caused by susceptible Gram-positive and Gram-negative bacteria.

**Contraindications:** Penicillin, cephalosporin and antigen allergy.

**Dosage:** Adults: 250-500 mg. every 6 hrs.

Children: 50-100 mg./kg/day

**Supplied:** Chewable tablets—125 mg.

**GELUSIL-M Antacid**

o-t-c

**Manufacturer:** Warner-Chilcott

**Composition:** Magnesium trisilicate

Aluminum hydroxide

Magnesium hydroxide

**Indications:** Peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis and control of hyperacidity

**Contraindications:** Renal insufficiency

**Dosage:** 1 or 2 tablets between meals and at bedtime.

**Supplied:** Tablets

## Perforation of the Caecum

(Continued from page 566)

### Summary

We have reported a child who suffered a laceration of the caecum from an automobile accident. He was resuscitated with intravenous fluids and whole blood and operated upon. The ready availability of a laboratory for the determination of arterial blood gases led to the diagnosis of incipient post-operative respiratory failure and its successful treatment with artificial ventilation. He then went on to survive the complications of wound sepsis and evisceration.

### References

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**COOK COUNTY**  
**Graduate School of Medicine**  
**CONTINUING EDUCATION COURSES**  
**STARTING DATES—1969**

SPECIALTY REVIEW COURSE IN PEDIATRICS, November 10  
 SPECIALTY REVIEW COURSE IN MEDICINE, Part II, Nov. 10  
 SPECIALTY REVIEW COURSE IN SURGERY, Part II, Dec. 1  
 SPECIALTY REVIEW COURSE IN ORTHOPEDICS, Nov. 17 & Dec. 8  
 PATHOLOGY REVIEW COURSES FOR SPECIALTIES, Request Dates  
 BLOOD VESSEL SURGERY, One Week, November 10  
 UROLOGY FOR GENERAL PRACTITIONERS, Two Days, Nov. 21  
 SYMPOSIUM ON SHOCK, Two Days, December 19  
 PROCTOSCOPY & VARICOSE VEINS, One Week, Dec. 15  
 SURGICAL & RADIATION TREATMENT OF GYNECOLOGICAL MALIGNANCIES, One Week, December 1  
 VAGINAL SURGERY, One Week, December 8  
 GENERAL PEDIATRICS, One Week, December 1  
 ADVANCES IN MEDICINE, One Week, December 1  
 REGIONAL ANESTHESIA, One Week, November 17  
 RADIOISOTOPES, One or Two Weeks, Request Dates

*Information concerning numerous other continuation courses available upon request.*

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	3 insertions .....	\$14.00
	6 insertions .....	\$24.00
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Cash with order. No general advertising accepted in classified column.

All copy must be typewritten on letterhead or business stationery of the advertiser. Instructions must state number of insertions, including time of first insertion. In the absence of this information, advertisements will be billed at the time of the first insertion, (when the ad appears for the first time).

Deadline for classified copy is the 20th of month preceding publication date. For example: copy for an ad scheduled for September issue, must be in hands of publisher not later than August 20. Publication date is 15th of each month. Copy received after deadline will be processed for following issue unless advertiser advises otherwise. Send all copy attention advertising department, Illinois Medical Journal, 360 N. Michigan Ave., Chicago 60601—Suite 2010.

## Obituaries

**Samuel Billows**, Chicago, died October 4 at the age of 81. He was retired to Miami Beach, Fla.

\***Donald D. Burroughs**, Peoria, died September 22 at the age of 65. He practiced in Peoria for the last 34 years.

\***Jack R. Davis**, Chicago, died September 23 at the age of 54. He was a general practitioner.

\***John W. Delehant**, Hometown, died September 9 at the age of 29. He was named "intern of the year" in 1967 at Little Company of Mary Hospital.

**Samuel Dessen**, Chicago, died May 23 at the age of 67.

**James E. Fitzgerald**, Chicago, died September 21 at the age of 78. He was past president of the Chicago Gynecological Society.

\***Richard Fried**, Hollywood, died September 15 at the age of 79. He was on the staff at Norwegian-American Hospital.

\***D. C. Good**, Danville, died September 5 at the age of 73. He was very active in civic and religious affairs.

\***Matthew J. Kiley**, Chicago, died September 8 at the age of 78. He was senior attending gynecologist at the former St. Luke's Hospital.

\***Rudolph Kimmerling**, Chicago, died September 18 at the age of 54. He was on the staff of St. Elizabeth's Hospital where he died.

\***Dino G. Maurizi**, Chicago, died September 11 at the age of 38. He was an associate professor at the University of Illinois Medical School.

**Florian Ostrowski**, Chicago, died September 23 at the age of 82.

\***Aleksas R. Rozenas**, Chicago, died September 9 at the age of 47. He graduated from medical school in Munich, Germany.

**Frederick L. Sperry**, Oak Park, died September 2 at the age of 73.

\***Charles J. Thill**, Chicago, died September 17 at the age of 56. He was assistant dean of Loyola University's Stritch School of Medicine.

**Anthony C. Tivilini**, Chicago, died September 12 at the age of 70.

**A. L. Zacharia**, Rockford, died September 11 at the age of 66.

\*Indicates Member of Illinois State Medical Society.



# BLUE SHIELD REPORT



## FOR *Illinois Physicians*

PUBLISHED MONTHLY BY: BLUE SHIELD PLAN OF ILLINOIS MEDICAL SERVICE • 222 NORTH DEARBORN ST. • CHICAGO, ILLINOIS 60601

Vol. 3, No. 12

December, 1969

### Blue Cross Increases Benefits For New Medicare Charges

For the second time in a year, Illinois Blue Cross has increased its benefits to members 65 and over with no increase in rates.

As announced by Social Security Commissioner, Robert W. Ball, the deductible and coinsurance features of Part A of Medicare—the hospital portion of the program—are being increased effective January 1, 1970.

#### Revised Medicare Charges

The initial hospital deductible for each benefit period will be increased from \$44 to \$52.

The daily charge for a hospital stay from the 61st through the 90th day will be increased from \$11 to \$13 a day.

The daily charge for a hospital patient who remains beyond 90 days (utilizing his lifetime reserve days of care) will be increased from \$22 to \$26 a day.

For patients in an extended care facility, the daily charge from the 21st through the 100th day will be increased from \$5.50 to \$6.50 a day.

Blue Cross will absorb these increased Medicare charges, amounting to 18 per cent, without any increase in rates to its members over 65, whether in small community-rated groups or on an individual payment basis.

Robert M. Redinger, chief executive officer of Illinois Blue Cross and Blue Shield, said: "We are extremely pleased to be able to provide our members 65 and over with this substantial increase in benefits without any increase in rates.

"In the inflationary period we are currently experiencing, those living on fixed incomes suffer the greatest from rising prices. Therefore, this increase in benefits without a corresponding increase in rates is particularly helpful to those 65 and over."

For your patients in the hospital, Blue Cross and Blue Shield continue to provide the kind of practical protection needed to fill the gaps not covered under Medicare.

### National Blue Shield Conference Hears Calls For Change

Some views were expressed on the challenge of the 70's at the Blue Shield National Program Conference, October 30-31, at San Francisco.

C. Howard Shillington, executive director, Trans Canada Medical Plans, Toronto, declared:

"The Canadian national health insurance program came about because of a substantial lack of health care in the poorer provinces and among the unskilled and lower income people. While the voluntary plans had a tremendous story of achievement to tell, the degree of confused leadership within the profession itself, and the resultant effect on the physician sponsored non-profit plans weakened our voices at a time when unity of purpose would have been desirable."

According to Roger O. Egeberg, M.D., HEW assistant secretary for Health and Scientific affairs:

"Some of us have to be reminded that there are some 30 million people whose health care needs are not being met. Before bringing those who are not now receiving proper health care into the mainstream of medicine, there must be changes made in the delivery system.

"Adding 30 million people to the present health care system will, on the average, add about 16 hours to a doctor's work week. The answer to this is to make more efficient use of paramedical personnel.

"Individual practice by physicians will continue although it proves to be an inefficient method. As medicine becomes complicated and progress is made, group practice of many types seems likely."

George Himler, M.D., Chairman AMA's Committee on Planning and Development, advised:

"Planning and financing a nation-wide health program is beyond the capacity of government alone, as it is beyond that of any single one of the health professions. I see no practical alternative for the health professions but to organize an effective, interdisciplinary health planning agency to identify health needs in all categories and recommend systems and methods to meet those needs.

"Blue Shield, as a member of the family of health professions, shares the professions' interests and responsibilities and should take part in their joint endeavors."

## ASK BLUE SHIELD

### • • • ABOUT MEDICARE

## When You Accept Assignment . . .

When a physician accepts assignment for unpaid charges, he may not bill the patient for any charges disallowed as higher than "usual and customary."

The reverse side of the 1490, "Request for Payment" form states, "If you and your doctor agree, Medicare will pay him directly. . . . Under this method the doctor agrees to accept the charge determination of the Medicare carrier as the full charge. . . ."

The physician may, however, bill the patient for any amount applied toward the annual \$50.00 deductible, the 20% co-insurance amount, and any charges disallowed as non-covered under Part B Medicare.

When the physician and his patient agree to an assignment, the patient must sign the "Request for Payment" form unless the patient is deceased or is a Public Aid Recipient. The physician must also sign the form and check the box marked "I accept assignment."

If the patient is unable to sign, a relative may sign for him. The relative must sign item #6 of the 1490 and indicate the patient's name, the relationship, and why the patient was unable to sign.

A physician treating a patient over an extended period does not have to obtain the patient's signature each time he accepts an assignment. However, he can obtain the patient's consent to an assignment of unpaid charges for the anticipated period of treatment by having the patient sign a brief statement such as: "I request that payment under the medical insurance program be made directly to Doctor \_\_\_\_\_ on any unpaid bills for services furnished me by that physician during the period \_\_\_\_\_ to \_\_\_\_\_." However, the period should extend no later than the close of the calendar year. A copy of the signed statement should be attached to a 1490 claim form and submitted as usual. Subsequent claims should then be submitted with the statement below. When the physician submits the 1490 form for assigned payments, he should indicate in the patient's signature space, "This is a continuation of a course of treatment for which patient's assignment was previously obtained."

## Part B Deductible Increase Expected

Commissioner Robert Ball told the House Ways and Means Committee that the monthly Part B Medicare premiums will be raised July 1, 1970 from \$4.00 to "somewhat over \$5.00."

The amount of the increase will be determined by the Department of Health, Education and Welfare and announced by the end of the calendar year.

The increase will affect the approximately 19 million people who are enrolled in Part B Medicare.

## How To Speed Medicare Payments

In order to speed Medicare payments, we suggest that separate claims be submitted for medical services rendered in 1969 and 1970. When we receive a claim with dates of service extending over two calendar years, we must separate the charges for two years and process them as two different claims. This will not only delay the claim, but could cause confusion to your medical assistant when two Explanation of Benefits are received.

It is necessary for us to separate the charges to determine accurately the patient's annual deductible.

### IMPORTANT REMINDER

This is a reminder that all claims for services rendered October 1, 1967 through September 30, 1968 must be filed no later than December 31, 1969.

Please submit these claims to the Medicare carrier (Blue Shield for the counties of Cook, DuPage, Kane, Lake and Will) by December 31, 1969.

### Let Us Help

For assistance in matters pertaining to Blue Shield in general and Medicare in particular, contact one of our Physician Representatives in our Professional Relations Department, 661-2963, Blue Shield Plan of Illinois Medical Service, 222 North Dearborn, Chicago 60601.



# new Gelusil-M<sup>®</sup> Tablets

Contains a combination of magnesium trisilicate, aluminum hydroxide (Warner-Chilcott) and magnesium hydroxide.

**for a difference in taste  
you can feel**

## **taste, texture and acceptance**

Derived from the manna tree, mannitol has been used for centuries to improve taste, texture and consistency of foods. Now, synthesized, mannitol is incorporated in Gelusil-M Tablets to achieve just the right liquid-smooth 'mouthfeel' and easier chewability.

## **prolonged buffering\***

Average onset to reach pH 3.5, 3.2 min. (Range: 2.0—6.0)

Average mean peak pH, 6.2 (Range: 3.5—7.2)

Average duration of buffering

above pH 3.5, 24.8 min. (Range: 8.0—34.0)

Average data presented derived from intragastric buffering studies obtained in 10 normal subjects, and are representative of other studies conducted with Gelusil-M Tablets.

## **ulcer symptoms relief\***

Gelusil-M Tablets provided prompt, temporary relief of heartburn and epigastric pain in two comparable groups of patients (50 and 51) presenting these symptoms. A summary of the results of these two studies showed speed of relief to occur within 5 minutes in 53.4% of patients, within 15 minutes in 95%. Relief was complete in 53.5% of the patients, partial in 38%, and lasted ½ hour or longer in 86.2% of the patients, one hour or longer in 53.5%.

**Indications:** Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required. **Precaution:** Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia. **Dosage:** One to two tablets between meals and at bedtime or whenever symptoms occur. If diarrhea occurs, reduce dosage or discontinue use. One tablet is equivalent to one teaspoonful of Gelusil-M Liquid. Tablets should be chewed. **Supplied:** Gelusil-M Tablets are packaged in boxes of 100 tablets (containing 10 push-out blister cards of 10 tablets each).

\***Reference:** Antacid Studies, data on file, Warner-Lambert Research Institute.



WARNER-CHILCOTT  
Morris Plains, New Jersey 07950



## ON THE COVER

The restoration of the Old State Capitol in Springfield was recently completed. The edifice was opened to the public on November 15.

The old Capitol which stood in the center square was practically a second home to Abraham Lincoln. It is rich in historical connections to this great man.

Considered a perfect example of Greek Revival Architecture, the building was at one time called "the most historic building west of the Allegheny Mountains." Now completely restored to its original magnificence, this is destined to become a national shrine of historical importance.

This building was the state's fifth capitol. It is two stories, 59 feet from grade to roof peak, and another 54 feet 3 inches in the cupola. The flag pole is 36 feet

high. In length and width the edifice measures 123 feet and 89 feet. The stone walls, with their backing of brick and plaster measured 2 feet, 9 inches thick. The dolomitic limestone used to form the pillars and columns was mined in a quarry under present Lake Springfield.

Visitors to the building will walk the halls where such immortals as Lincoln, Douglas, Ulysses S. Grant, John Logan, Richard Oglesby also trod. It is a bit of Americana no one should miss.

With this issue the editors and staff of the **Illinois Medical Journal** extend to all readers and advertisers sincere best wishes for a Happy Holiday Season. The hope is that all will have a happy, prosperous, healthful New Year.

### NEW

### PHARMACEUTICAL SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturer's package insert or brochure.

**Single Chemicals:** Drugs not previously known, including new salts.

**Duplicate Single Products:** Drugs marketed by more than one manufacturer.

**Combination Products:** Drugs consisting of two or more active ingredients.

**New Dosage Forms:** Of a previously introduced product.

A new drug application has been granted by the Food and Drug Administration for the following, but no marketing date has been announced:

**SINEQUAN:** Psychotherapeutic drug for anxiety and depression

**Nonproprietary Name:** Doxepin HCl

**Manufacturer:** Pfizer

**New Indications** have been approved by the FDA for the following old drugs:

**PERIACTIN** Appetite stimulant

**Nonproprietary Name:** Cyproheptadine HCl

**Manufacturer:** Merck Sharp & Dohme

**XYLOCAINE HCl** Antiarrhythmic agent

**Nonproprietary Name:** Lidocaine HCl

**Manufacturer:** Astra Pharmaceutical

**The following new drugs have been marketed:**

### NEW SINGLE CHEMICALS

**GUIDE** Tranquilizing Agent

R

**Manufacturer:** Dow Chemical

**Nonproprietary Name:** Piperacetazine

**Indications:** Hyperactivity, agitation and anxiety states associated with acute and chronic schizophrenic reactions in adults.

**Contraindications:** Comatose or markedly depressed patients. Blood dyscrasias, bone marrow depressions, liver disease, pregnancy, and lactation. Use in children under 12 not recommended.

**Dosage:** 2.5-2.6 mg./kg./day.

**Supplied:** Tablets—10 mg.

**TESLAC** Cancer Chemotherapy

R

**Manufacturer:** Squibb

**Nonproprietary Name:** Testolactone (USAN)

**Indications:** Palliative management of advanced or disseminated mammary cancer without masculinization.

**Contraindications:** None known.

**Dosage:** i.m.: 100 mg. 3 times a week

**Supplied:** Vials—5 cc

### DUPLICATE SINGLE PRODUCTS

**HYPAQUE MEGLUMINE 60%** Radiopaque medium

R

**Manufacturer:** Winthrop

**Nonproprietary Name:** Meglumine Diatrizoate (USP)

**Indications:** Cerebral and peripheral angiography and excretory urography.

**Contraindications:** Do not use for myelography. Observe caution with individuals who are pregnant, have pheochromocytoma or are homozygous for sickle cell disease.

**Dosage:** Children: 2-12 yrs.: 5-15 ml.

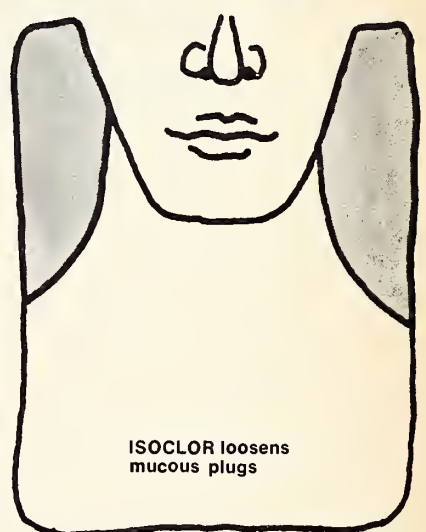
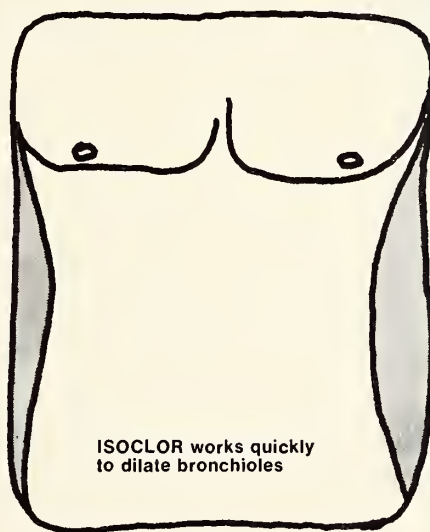
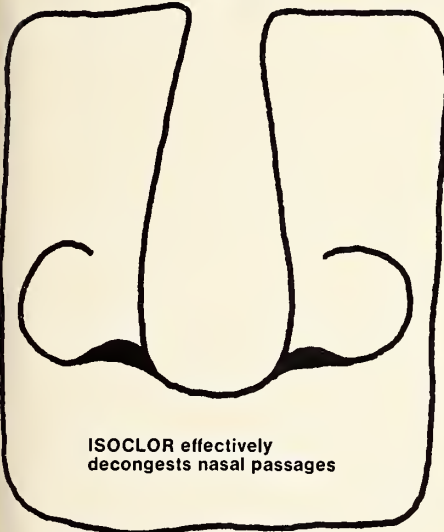
Over 12 yrs.: 15-30 ml.

Adults: 30-60 ml.

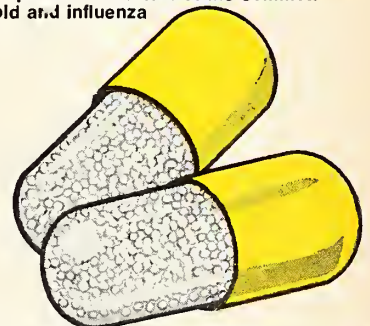
**Supplied:** Ampuls—30 ml. with 1 ml. sensitivity test ampul. Vials—20, 30 and 50 ml., rubber stoppered with sufficient excess to withdraw 1 ml. for sensitivity test.

(Continued on page 750)

# HERE ARE THE COLD FACTS:



ISOCLOR promptly and effectively combats  
symptomatic miseries of the common  
cold and influenza



ISOCLOR helps patients face the cold facts

## ISOCLOR<sup>®</sup>

Isoclor provides quick, long lasting relief of respiratory congestion and discomfort brought on by common colds, influenza, and allergies. Isoclor contains chlorpheniramine maleate — one of the most potent and safest antihistamines. And pseudoephedrine HCl — a decongestant bronchodilator providing effective and long lasting relief for the entire respiratory tract. Both work to extend the range of relief.

**COMPOSITION:** Each tablet or 2 teaspoonfuls of liquid contains:  
Chlorpheniramine Maleate..... 4 mg.  
Pseudoephedrine HCl..... 25 mg.

**Each ISOCLOR Timesule contains:**

Chlorpheniramine Maleate..... 10 mg.  
Pseudoephedrine HCl..... 65 mg.  
In a special pellet form providing both prompt and sustained effect.

**INDICATIONS:** For symptomatic relief of colds, hay fever, allergic conjunctivitis, perennial rhinitis of allergic origin and sinusitis. Opens nasal, sinus and bronchial passages orally.

**CONTRAINDICATIONS:** Sensitivity to antihistamines or sympathomimetic agents. Severe hypertension or severe cardiac disease.

**PRECAUTIONS:** Use with caution in patients suffering with hyperthyroidism. Patients susceptible to the soporific effects of chlorpheniramine should be warned against driving or operating machinery should drowsiness occur.

**CAUTION:** Federal law prohibits dispensing without prescription.

**SUPPLIED:** Tablets: Bottles of 100 and 1000. Liquid: 4 oz. bottles, pints, and gallons; Timesules: Bottles of 50, 250, and 1000.

DOSAGE AND ADMINISTRATION:	Tablets	Liquid	Timesule
Adults:	1 q. 4 h.	2 tsp. q. 3-4 h.	1 q. 12 h.
Children 6-12 years:		1 tsp. q. 3-4 h.	
40-50 pounds:		¾-1 tsp. q. 3-4 h.	
30-40 pounds:		½-¾ tsp. q. 3-4 h.	
20-30 pounds:		¼-½ tsp. q. 3-4 h.	
15-20 pounds:		⅛-¼ tsp. q. 3-4 h.	



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Edward W. Cannady, M.D.

# The President's Page

## Peer Review Seminar Scheduled

★ Dr. Smith visits an elderly medicare patient weekly. Medicare tells him these visits are not medically necessary. Dr. Smith is convinced he is practicing good medicine and deserves payment.

Where can he go for help?

★ Dr. Jones travels 30 miles to an ECF to visit five medicare patients. He bills each for a house call, but medicare reduces his bill to the level of an office visit. Dr. Jones believes he has been treated unfairly.

Where can he go to have his case heard?

★ A medicare carrier agrees to pay Dr. Black his fee for a surgical procedure. The carrier says this fee is to include the routine post-operative care. After a week, Dr. Black bills medicare for daily hospital visits. The carrier believes all follow-up visits related to the surgery should be included in the surgical allowance.

Where can the medicare carrier go for an objective medical opinion?

These are but a few examples of problems that arise every day throughout Illinois.

A solution to these problems must be found and found quickly. The public image of our profession is at stake and the threat of possible governmental control is close at hand.

The Illinois State Medical Society is keenly aware of the need for an effective peer review mechanism and will present such a plan at the Leadership Conference Sunday, February 8, 1970, at the Blackstone Hotel in Chicago. At that time, guidelines will be given to district and county peer review committees.

I hope every county medical society will be represented at this vitally important Peer Review Seminar!

We all recognize the need for a workable peer review structure. Such a mechanism should be considered a positive approach to solving the inadequacies and irregularities in providing quality health care. It is a vehicle whereby quality medical care can be maintained within the framework of "usual, customary, and reasonable" fees for a particular service in a respective geographic area. It will keep utilization of services and facilities consistent with accepted standards of practice and at an acceptable cost in an inflationary economy.

In order to make any peer review mechanism work, it must have full cooperation from all levels of organized medicine . . . beginning with the county medical society. Here is where all peer review should start.

Therefore, I again urge county society officers to have their peer review committees attend the ISMS Seminar, and appoint committees where none now exist. Only with full participation can this vital program succeed.

At the Peer Review Seminar you can get the answers for such questions as:

- how does a peer review committee differ from grievance or utilization committees?
- how does a county organize a peer review committee?
- in a very small county medical society, how many physicians must be on a peer review committee?
- are there any "teeth" in peer review?
- what about MDs who are not ISMS members?

*(Continued on page 748)*



# Abstracts Of Board Actions

Board of Trustees Meeting

October 11-12, 1969

Hotel Pere Marquette, Peoria

*These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.*

## Council on Continuing Education Discussed

ISMS President Edward W. Cannady reported further progress on the establishment of an Independent Council on Continuing Education for physicians in Illinois. Dr. George Miller, of the University of Illinois College of Medicine, has proposed a plan jointly involving the Center for Educational Development, University of Illinois College of Medicine, and RMP. The Plan would require an assessment on ISMS members. Dr. Miller will appear at the January Board meeting to discuss the concept.

## Objection to Bi-State Planning Board Representation Voiced

In developing new by-laws for the Bi-State Program for Area-wide Comprehensive Health Care Planning Organization (Metropolitan St. Louis and three adjacent Illinois counties), consumer representation on the board would be arbitrarily set at 60% rather than 51% as required by law. The St. Clair County Medical Society has expressed strong opposition to this move to limit provider representation. The ISMS Board, by official action, officially opposed this and authorized a telegram to be dispatched to the appropriate officials of the Bi-State organization about this matter.

## Official Specialty Society Representation on Councils

The Policy Committee was instructed to study the feasibility of official specialty society representation on ISMS Councils. This was prompted after discussion evoked the idea that this may prevent further splintering or fractionalizing of medicine and would serve a unification purpose. The suggestion was proposed as a means for liaison and closer working relationships between specialties in organized medicine. Numerous specialty society leaders currently serve on ISMS Councils, but not in an official capacity of their specialty society.

## "Operation Integrity" Reports

The Board directed that a request be forwarded to the Blue Shield Board of Directors to ascertain their position on a program to check on services to medicare patients. This so-called "Operation Integrity" was reported as being conducted by direction of the Social Security Administration. The program involves inquiry to a random sampling of medicare patients asking them to verify that the services billed were actually rendered.

In related action the Board requested the ISMS Delegation to the AMA to introduce a resolution at the Denver Clinical meeting calling upon the AMA to join in objecting to this intrusion on the part of the SSA. "The action impugns the honesty of every physician in Illinois", according to Dr. Thomsen, who called for the resolution.

#### Laboratory Services to be Defined

Is the service of a clinical laboratory through its report the practice of medicine? The question was posed and referred to the Laboratory Services Committee to study and report back to the Board.

#### Medical-Legal Guide

A proposal from the Insurance Committee to develop and publish a medical-legal guide for distribution to all Illinois physicians was favorably received. The production cost would be under-written by the ISMS professional liability group plan administrator. It would be entitled "Medical-Legal Guide for Physicians." The matter was referred to the Finance Committee for further action on the availability of funds for mailing, and other distribution costs.

#### DVR Asked to Pay Usual and Customary Fees

Upon recommendation of the Council on Economics and Government Health Programs the Board approved transmittal of a request to the Division of Vocational Rehabilitation that it up-date its present fee schedule to pay usual and customary fees.

#### Status of Advisory Committee to IDPA Defined

Upon advice of legal counsel the status of the Medical Advisory Committee to IDPA was clarified. The committee is a Departmental committee established under authority granted in the Illinois statutes. It is not a committee of ISMS, although the membership is appointed upon recommendation of ISMS. The committee's deliberations and recommendations on the medical aspects of the public aid program are advisory only to the Department. All action is taken by the Department itself, thus eliminating any liability on the part of either the committee or ISMS for disciplinary actions taken. Henceforth, any reports from the Committee to ISMS will be for information only.

#### Peer Review Seminar to be Scheduled

Supplementing previous action in support of peer review, the Board authorized activation of a program through county and district prepayment plans and organizations committees. Details of the program will be presented to county society leaders and district committees through a seminar in conjunction with the annual leadership conference scheduled early next year.

#### Financial Aid to Medical Students and SAMA

Upon recommendation of the Council on Education and Manpower, the Board authorized an appeal to all members of ISMS to contribute a minimum of \$10 to the ISMS Educational and Scientific Foundation to provide funds to needy medical students this year, because of the reduction of available federal funds for scholarships and loans. In related action the Board endorsed the concept of sustaining memberships of physicians in SAMA and approved an appeal over the signature of the president urging members to join. The Board also approved the introduction of a resolution by the AMA delegation at the Denver meeting calling for the establishment of procedures to forgive or defer the interest on AMA-ERF loans until after graduation.

*(Abstracts continued on page 710)*



## *Spontaneous Rupture Of Pregnant Uterus\**

BY HAROLD E. SMITH, M.D., F.A.C.S., F.A.C.O.G./BROADVIEW

Rupture of the uterus associated with a traumatic delivery or associated with previous sections is not too rare an identity, or too difficult to diagnose. Eastman states that rupture of uterus causes 5% of all maternal deaths.

Spontaneous rupture of a pregnant uterus, without any previous surgery having been performed on it, and before the 30th week of gestation, is exceedingly rare and presents a difficult diagnostic problem.

The normal implantation of the placenta occurs as far as the spongy layer of the decidua. This protective fibrinous layer is called the Nitabuch layer and prevents the trophoblastic cells of the chorionic villi from penetrating further into the muscular layer. It is through this area that the layers separate for the third stage of labor.

The many factors that allow the trophoblastic cells to invade through the decidua are divided into constitutional, and acquired factors. The constitutional factors would be chiefly anatomical defects. The acquired factors are puerperal sepsis involving endometrium and myometrium, trauma associated with curettage, forceful removal of placenta, irradiation, submucous fibroids and miscellaneous surgery of the uterus.

The types of placenta that are involved in these conditions are the accreta type, which includes the increta and percreta. The degree of penetration of the chorionic

villi into the endometrium and muscular layer, is the diagnosing factor. The accreta is the superficial adherent one, the increta is the deeper penetrating one, and the percreta is the complete invasion to the serosal surface.

Sumawong, et al., states that a diagnosis before the placental stage of labor is possible only in the placenta percreta where uterine rupture has caused intra peritoneal hemorrhage, a possibility at any time during the pregnancy. Thus, when signs of internal hemorrhage occur in a pregnant woman in early to mid-pregnancy, the diagnosis of placenta percreta should be considered. Before rupture occurs, most patients will experience unusual abdominal discomfort associated with intermittent hardness of the uterus and periodic spotting may also occur.

Katzman reports the invasive type of placenta, especially into the previous caesarean scar, is still infrequent, but a spontaneous rupture of the invasive placenta through the protective lining of the uterus and the muscle is a rare finding, caused by the placenta percreta.

Sumawong et al., reports three cases of percreta. Two were diagnosed before the

\* This paper presented at Summer meeting of Illinois Obstetrical Gynecological Society September 12, 1968.

Harold E. Smith, M.D., a Broadview physician specializing in obstetrics and gynecology, is a graduate of Rush Medical College. In addition, he is a member of the American College of Obstetricians & Gynecologists, the International College of Surgeons and the American College of Surgeons.



onset of labor. One patient had a history of a previous section and the other had a placenta removed manually followed by puerperal sepsis in her previous labor. The third was diagnosed when signs of intra peritoneal hemorrhage developed after a prolonged and hazardous 3rd stage, with manual removal followed with intra uterine curettage.

Direct quote from Sumawong et al's. recent article: "Placenta accreta is a very common condition. However, authors allow that many cases have gone undiagnosed and more than 300 have been reported. Placenta percreta is especially rare. Golden and Betson reviewed the literature from 1900, when first case of placenta percreta was reported in 1959. They found that only 15 cases of placenta percreta, resulting in rupture of the uterus, had been reported and reported two such cases of their own. In 1930, another case of placenta percreta and uterine rupture in a patient of Klostermans was cited by Kwartin and Adler. Three additional cases reported in 1949 by Petil and Mitchell and Associates. Since 1959, 10 more cases have been reported. This paper discusses three such cases making a total of 33 cases of spontaneous rupture of uterus due to placenta percreta since 1900."

This case that I am reporting would add another case of percreta with spontaneous rupture of uterus in second trimester of pregnancy. Diagnosis is difficult. Symptoms are generally those of a patient in early pregnancy with history of increasing lower abdominal pain and some evidence of shock.

Placenta praevia or abruptio are considered as possibilities, but evidence of internal bleeding necessitates a cul-de-sac puncture. If blood is found, the diagnosis is made and a total or subtotal hysterectomy is done, depending on condition of patient. Sufficient blood replacement is given.

### Case Report

Gravida 11, para 1, first pregnancy in 1961, normal delivery complicated with a post-partem endometritis. Recovery in 12 days. Admitted to hospital October 16, 1965, with spotting and abdominal pain. She was discharged October 22, 1965, with diagnosis of threatened abortion. Her last menstrual period was June 27, 1965. Re-

admitted November 29, 1965, in 22nd week of pregnancy because of severe lower abdominal pain with evidence of shock. Her condition appeared to temporarily improve, then rapidly deteriorated. Consultation at this time advised a cul-de-sac puncture. Non-clotting blood was obtained. Immediate surgery was done under local, then general, anesthesia. About 2,000 cc. of blood was found in the pelvis and lower abdominal cavity. A large ragged laceration was found in the posterior wall of the uterus with placenta and foetus protruding into the abdominal cavity. A subtotal hysterectomy was performed. Foetus was stillborn with a weight of 2 lbs. 10 oz. Seven pints of blood were given during surgery and the immediate postpartum period. The patient discharged on tenth postpartum day with a 36% hematocrit. Pathological report confirmed the diagnosis of placenta percreta, causing a ragged laceration of the posterior portion of the uterine wall. The placenta could not be removed without further tearing of the uterine wall. The microscopic sections of the uterine wall at the ruptured fundal region, show a thin rim of hyalinized fibrosed myometrium with decidual reaction. The inner surface is infiltrated by chorionic villi and the serosal surface is hemorrhagic and necrotic. Diagnosis: Placenta percreta and placenta praevia.

### Conclusions

1. Spontaneous rupture of a pregnant uterus in the second trimester due to placenta percreta.
2. Other cases are reviewed as reported in the literature of placenta percreta, adding this one to the number.
3. Factors predisposing to this condition are given. Endometritis associated with first pregnancy is the probable etiological cause of this case.
4. Immediate surgical intervention in case of apparent shock due to hemorrhage is imperative. If diagnosis then is placenta percreta, total or subtotal hysterectomy is indicated depending on condition of patient.

### References

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(Continued on page 750)

# Coronary Care Unit Experience

## Clinical Experience at Mercy Hospital and Medical Center

BY HADI DIZADJI, M.D. AND GEORGE F. O'BRIEN, M.D./CHICAGO

*The splendid achievements obtained in Coronary Care Units have been heralded by many investigators. Details of the physical arrangement, administration, and medical procedures were outlined in a review published by the National Conference on Coronary Care Units.<sup>1</sup>*

*A recent classical paper by Dr. Bernard Lown<sup>2</sup> emphasized the importance of preventing cardiac arrhythmias. Controversy over the methods of prevention still exists. Continuous study and rigid evaluation of the results obtained on patients treated for myocardial infarction in well controlled intensive care environment will do much to allay the disquietude of staff physicians. The purpose of this paper is to report our experience in the Coronary Care Unit at Mercy Hospital and Medical Center, Chicago, during the 14 month period between July, 1966 and December 1, 1967.*

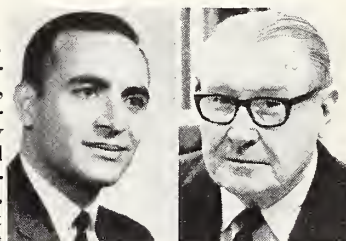
### Materials And Methods

Patients are hospitalized in the Coronary Care Unit as soon as possible after the onset of an attack. The Unit is equipped with continuous EKG monitoring devices, audio-visual alarm systems, a defibrillator and mechanical ventilatory facilities. The staff is specially trained and nurses assigned to the unit are vigilant and competent in the detection of arrhythmias. They are also instructed and prepared to institute immediate treatment. The personnel operate under the constant supervision of a medical director and other consultants especially interested in cardio-vascular diseases.

Patients are confined to bed in a room equipped with monitoring systems. Curtain partitions separate the beds. Early detection and treatment of minor arrhythmias is a major objective. It is only by diligent observation and treatment of early and seemingly minor arrhythmias that the more serious and often lethal ones can be prevented. Rapid accumulation of experience has enabled us to devise a guideline for the treatment of myocardial infarction and its complications. The following is part of the guideline presently in use by our house staff in the Coronary Care Unit. The guideline established by Dr. Lown has been our main reference.<sup>2</sup>

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Hadi Dizadji, M.D., is medical director, Clinical Cardiology, Mercy Hospital and Medical Center, Chicago. A cardiologist and Assistant



Clinical Professor, Dept. of Medicine, at Loyola University, Stritch School of Medicine, he is a graduate of the University of Tehran, School of Medicine. Dr. Dizadji is a Diplomate of the American Board of Internal Medicine and is certified by the American Subspecialty Board of Cardiovascular Disease. George F. O'Brien, M.D., is chairman, Dept. of Medicine, Section of Internal Medicine, Mercy Hospital. He is a graduate of Rush Medical School and an Emeritus Professor of Medicine, Stritch School of Medicine.

## Guideline

### Suggestions For The Care And Treatment Of Patients With Myocardial Infarction, Acute Heart Failure, Shock And Arrhythmias

#### General Information:

Medical management of the patient is the responsibility of the attending physician and his consultants. The responsible house staff uses the prescribed guideline until such time as the attending physician visits the patient and assumes personal responsibility. If there is any factor delaying the institution of proper treatment, the Medical Director of the Intensive and Coronary Care Unit is notified by the resident. *Treatment For Uncomplicated Myocardial Infarction:*

1. Place the patient in a reverse trendelenberg position at an angle of 10-20 degrees.
2. Relieve pain as soon as possible. Use morphine sulphate—15 mgs. demerol—75 mgs. or dilaudid 2 to 4 mgs. Have a good reason for your preference.
3. Employ oxygen as indicated.
4. Monitor the patient at once. If the patient is in cardiac arrest, treat as outlined in Cardiac Resuscitation Guideline.
5. Place the patient on a liquid diet.
6. Order SGOT, LDH, and EKG.
7. Start an intravenous fluid, 5% D/W at once, to provide an avenue for rapid administration of anti-arrhythmic agents.

#### *Treatment For Complications Of Myocardial Infarction:*

##### A. Shock

##### 1. Vasopressor Drugs.

- (1) Aramine is administered in a concentration of 200-500 mgs. per 1,000 cc of 5% G/W. Adjust the rate of administration so as to keep the blood pressure about 20-30 mm Hg. below the blood pressure recorded before the infarction, or keep the systolic blood pressure around 100 mm Hg. Excessive amounts of vasopressor agents are harmful.<sup>3</sup>
- (2) Levophed may be given in doses of 4 mgs. per 1,000 cc of D/W, if there is no response to Aramine.

##### 2. Analgesics

Relieve the pain by giving morphine sulphate 10-15 mgs. or dilaudid 2-4 mgs. intravenously. Dissolve in 10 ml. of steril water.

##### 3. Oxygen

Oxygen is given by nasal catheter at the rate of 4-6 liters per minute.

##### 4. Digitalizing Drugs

Ouabain 0.2 mg. is given intravenously every 30 minutes for three doses providing the patient has not been digitalized. Digoxin 0.5 mg. intravenously or Cedilanid 0.4 mg. intravenously may be used if preferred. The dose may be repeated in 2 or 3 hours if necessary.

##### 5. Receptor Agents

Alpha receptor blocking agents such as Phenoxybenzamine, or a Beta receptor stimulant, such as Isoproterenol, have been advocated in the treatment of shock after myocardial infarction. The routine use of these drugs is not recommended. However, when the patient is not responding to the usual management, the resident, upon obtaining the attending physician's approval, may try these medications.

##### B. Acute Pulmonary Edema:

1. Place patients in the semi-upright position, unless signs of shock are present. Apply tourniquets to the extremities or perform phlebotomy.

##### 2. Analgesics:

- (1) Morphine sulphate, 10-15 mgs. is administered at once, giving it intravenously or subcutaneously, depending on the patient's condition.
- (2) Dilaudid 2 to 4 mgs. may be given intravenously or subcutaneously if the attending physician prefers. Nalline should be on hand in case the patient develops respiratory depression.

##### 3. Oxygen

Administer oxygen at the rate of 4-6 liters per minute. IPPB may be used.

##### 4. Aminophylline

Aminophylline may be slowly administered in doses of 500 mgs. in 250 cc 5% D/W, administered through the intravenous tube.

##### 5. Digitalizing Agents

Digoxin 1 mg. is given intravenously and is repeated in 3-4 hours if indi-



cated. Cedilanid 0.8 mgs. may be used.

6. *Diuretics*

Mercuhydrin 1 to 2 cc or ethacrynic acid 100 mgs. is given intravenously. Other diuretics may be used if preferred.

C. **Congestive Heart Failure:**

Treatment is similar but less vigorous than that employed for managing acute pulmonary edema.

D. **Arrhythmias, Associated With Myocardial Infarctions:**

1. *Ventricular Arrhythmias*

(1) Ventricular Premature Beats

a. Indications for treatment:

- (a) When ventricular premature beats occur early in the cycle, that is on the T wave, or when the distance from the Q wave to the premature beat is less than the normal QT interval (from the Q wave to the end of the T wave), or the ratio is less than 0.85 (Q to premature beat/QT ratio).
- (b) When salvos of three or more premature ventricular contractions occur frequently.
- (c) When multiform configurations of the premature ventricular complexes are present.
- (d) When frequency of the premature beats is greater than six per minute.

b. Treatment:

Give lidocaine 25 mgs. intravenously in a 2% solution. Wait for one minute. If no response is evident, give an additional 50 mgs. intravenously. When premature ventricular beats become infrequent, a continuous infusion of lidocaine is given at a rate sufficient to prevent the occurrence of further premature beats. Do not, however, exceed 2 mgs. of lidocaine per minute. In the event lidocaine is not effective, give procaine amide 100 mgs. intravenously over a period of 2 to 3 minutes. If premature ventricular beats continue, re-

peat the same dosage in two to three minutes. When the patient's rhythm is stabilized, place the patient on oral procaine amid employing doses of 500 mgs. Q.I.D. It may be administered every four hours or even every two hours, but the total daily dose should not exceed 3 gms. Try to arrive at the minimum dose that will prevent arrhythmia. If the required dose is more than 3 gms. per day, consult the director of the Cardiac Care Unit.

(2) *Ventricular Tachycardia*

Give lidocaine 50-100 mgs. intravenously or procaine amide 100 mgs. taking 2 to 3 minutes for administration. If the desired response is not obtained, the patient's general condition is compromised or the cardiac output and blood pressure are declining, cardioversion 100 Watts per second is to be considered.

2. *Atrial Arrhythmias:*

(1) Atrial Premature Beat:

If rare, disregard them; if frequent, or in the form of bigeminy or trigeminy, use quinidine 0.2 gms. Q.I.D.

(2) Atrial Flutter, fibrillation and tachycardia:

Digoxin, 0.5 mg. is administered intravenously; repeat every 3-4 hours until the desired effect is obtained. If the patient is not responding and his general condition is deteriorating, defibrillation with a defibrillator might be used.

(3) *Sinus Tachycardia & Bradycardia*  
Sinus tachycardia does not require treatment, unless it is associated with congestive heart failure. Sinus bradycardia may be treated with Atropine, especially if morphine is a possible contributing cause.

(4) *Heart Block*

In most leading cardiac centers in the U.S.A., the employment of a pacemaker is the treatment of choice in Complete A.V. Block. The demand pacemaker is preferred. If for any reason, the pacemaker is not used, Isuprel may be employed at a dose of 4 mgs. in

1,000 cc. of 5% G/W intravenously, adjusting the drip so as to produce a pulse rate of not more than 60 per minute. Isuprel may cause ventricular tachycardia, and therefore it should be given cautiously.<sup>5</sup>

## Results

One hundred consecutive patients with confirmed diagnoses of myocardial infarction were studied over a fourteen month period. Sixty seven of these were males, and 33 were females. Their ages ranged from 40 to 93 years. The mean age for the women was 65 years, and for the men, 60.7 years. Forty-four patients (44%) were over 65 years of age. Eighty seven patients had electrocardiographic changes diagnostic of myocardial infarction, while 13 were diagnosed by serum enzyme elevation and clinical history. The incidence of all types of arrhythmias in the 100 patients was 65%. Table 1 shows the incidence of individual arrhythmias.

If the number of successive ventricular premature beats was 6/min. or more, the arrhythmia was classified as a ventricular tachycardia. Most patients with either premature ventricular contraction or ventricular tachycardia responded favorably to the administration of lidocaine. One patient with a complete A-V Block responded favorably to Isuprel therapy.

Five patients had ventricular fibrillation without evidence of shock and two of them were successfully resuscitated. We were unsuccessful in resuscitating patients who had ventricular fibrillation and evidence of shock. Of the 100 patients treated, 19 died. Three of the 19 deaths resulted from sudden ventricular fibrillation without shock. Three patients died because of shock, congestive heart failure, and a terminal ventricular fibrillation. The remaining deaths were due to shock, myocardial rupture, and uncontrollable heart failure. The majority of deaths occurred during the first three days. Of the 19 deaths, 12 had autopsy findings which correlated with the clinical diagnoses. Among autopsy cases, there were two ventricular ruptures, both of which occurred during the first few days.

**Table 1**

Ventricular premature contraction .....	45
Atrial premature contraction .....	21
Sinus tachycardia .....	23
Atrial fibrillation .....	7
Ventricular tachycardia .....	6
Atrial flutter .....	4
Nodal tachycardia .....	3
Premature nodal contraction .....	3
Ventricular fibrillation .....	5
First degree A-V block .....	2
Complete A-V block .....	2
Atrial tachycardia .....	1
A-V dissociation .....	1
Asystole .....	1

## Comment

The incidence of arrhythmias and the reduction in the mortality rate in our Coronary Care Unit compares favorably with published reports.<sup>6-7</sup> The first 5 to 7 days are the most hazardous period in myocardial infarction. The occurrences of 47%, 63%, and 89% deaths during the first 24 hours, first three days, and first seven days, respectively, confirms this fact, and gives justification for an aggressive, organized, and prompt institution of therapy during the first week.

The incidence of ventricular fibrillation without shock in our study was 5%. This is somewhat lower than in other studies, but is higher than that reported by Dr. Lown. However, 90% of ventricular fibrillation occurred during the first seven months of our study, and there has been a noticeable reduction of ventricular fibrillation during recent months. Hence, there was only one ventricular fibrillation in the second seven months of our experience. Although this difference in the occurrence of ventricular fibrillation may be a coincidence, one cannot resist the temptation to conclude that aggressive and more organized treatment during the second period of our study was a contributing factor in preventing ventricular fibrillation. It is also noted that in spite of the decline in the incidence of ventricular fibrillation, the mortality rate was constant during the total period of our study. This indicates that the prevention of electrical disturbances, such as ventricular fibrillation, does not necessarily safeguard the patients against shock and congestive heart failure. In some patients, the underlying muscular injury is so severe that even if arrhythmias do not occur, they may die of mechanical failure. Arrhythmias in these patients are merely an early manifestation of a serious cardiac disturbance.

This is just speculation and needs further study and evaluation. However, it does not change the concept that early and prompt management of arrhythmias is the most important step in the treatment of myocardial infarction. We feel that a reduction from the overall mortality of 30-40% to 19% is a significant one. In addition, this reduction becomes more significant if one takes into consideration the mean age of the patients during this study and serious nature of the cardiac problems that necessitated their presence in the Cardiac Unit.

### Summary

Our experience in 100 consecutive patients with confirmed myocardial infarction treated in a Cardiac Care Unit during a 14 month period is reported. Nineteen percent of the patients died. This is considered to be a significant reduction in the mortality rate of myocardial infarction.

## Cold Aggravates Angina Pectoris

Exposure to cold aggravates angina pectoris by increasing the resistance to blood flow through the small peripheral vessels, according to a National Heart Institute study presented at sessions of the American Heart Association Meeting in Bal Harbour, Florida.

The increased peripheral resistance raises the blood pressure against which the already oxygen-hungry heart muscle must work to supply the same volume of blood. This may bring on or else aggravate chest pains resulting from exertion or other factors in patients with chronic coronary insufficiency.

The study was reported by Drs. Morris Stampfer, Stephen Epstein, George Beiser, Robert Goldstein and Eugene Braunwald of the Heart Institute's Cardiology Branch.

This study included 6 coronary patients with angina and 5 subjects without any coronary symptoms. All 11 were studied both at rest and during mild exercise in both a warm (76°F) and a moderately cold (59°F) environment.

Both patients and controls showed significant increases in total peripheral resistance and in arterial pressure at rest and during exercise in the colder environment. Although heart output and heart rate were not changed as a result of the cooler temperature alone, 3 of the coronary patients

It is concluded that among other factors, the promptness and organized method in instituting treatment was responsible for the reduction. ◀

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3. Weil, M.D., Shubin, H., **DIAGNOSIS AND TREATMENT OF SHOCK**, The Williams and Wilkins Company, Baltimore, 1967.
4. Gunnar, R., et al, "Ineffectiveness of Isoproterenol in Shock Due to Myocardial Infarction," *J.A.M.A.*, Dec. 25, 1967.
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6. Yu, P. N., Fox, S. M., Imloden, C. A., Jr., Killy, T., "Coronary Care Unit," *Modern Concept of Cardio-Vascular Disease*, 34:23, 1965.
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who felt no pain while exercising in the warm environment incurred angina with the same level of exercise in the cold.

The worsening of angina with cold exposure is all too familiar to thousands of coronary patients for whom physical exercise is always limited, at some level, by the clenching chest pain of an insufficient blood supply to the heart muscle. Heavy outdoor work in an icy wind would be an extreme example of this effect; but stepping into chilly bath water, or even contact with cold sheets, is sufficient to trigger or worsen the chest pain in many patients.

Modern cardiology texts have opined that it is a cold-induced increase in heart output that increases the work—and consequently the painful need for oxygen—of the heart muscle in these patients. However, the results from the NHI study suggest otherwise.

Since a cold environment causes an increase in the total peripheral vascular resistance, but not in the cardiac output of the subjects, the authors feel that it is probably the increased resistance to flow peripherally and the consequent increase in blood pressure induced by cold which heightens the myocardial oxygen demand. If the coronary blood supply is insufficient, this factor might well precipitate or intensify any attack of chest pain.



# EDITORIALS



## SHOULD GENERAL HOSPITALS ADMIT TB PATIENTS?

There is a growing feeling among physicians that the general hospital is the logical place for the treatment of tuberculous patients. Extended hospitalization rarely is needed, thanks to our effective antituberculosis drugs and modern methods of controlling infection. Authorities do agree that those with active tuberculosis should have an initial period of hospitalization but they are not quite in accord on whether all sanatoria should be closed.

The National Tuberculosis and Respiratory Disease Association published "Guidelines for the General Hospital in the Admission and Care of Tuberculous Patients." Board and staff members of general hospitals interested in admitting tuberculous patients should study this report carefully, as it is not so simple as it sounds.

According to this report, "Before a general hospital assumes responsibility for tuberculous patients, it must make sure that the following are provided:

- 1) Adequate consultation services.
- 2) Beds (when needed) to which patients with tuberculosis will be admitted.
- 3) Laboratory services competent in biochemical and bacteriologic techniques needed to diagnose and evaluate tuberculosis.
- 4) Necessary radiologic services.
- 5) An interested and understanding nursing staff.
- 6) An educational program to provide training and experience for all personnel, both professional and para-professional.
- 7) Necessary outpatient services and

follow-up.

The hospital need not provide all of these services itself as long as they are easily and adequately available elsewhere."

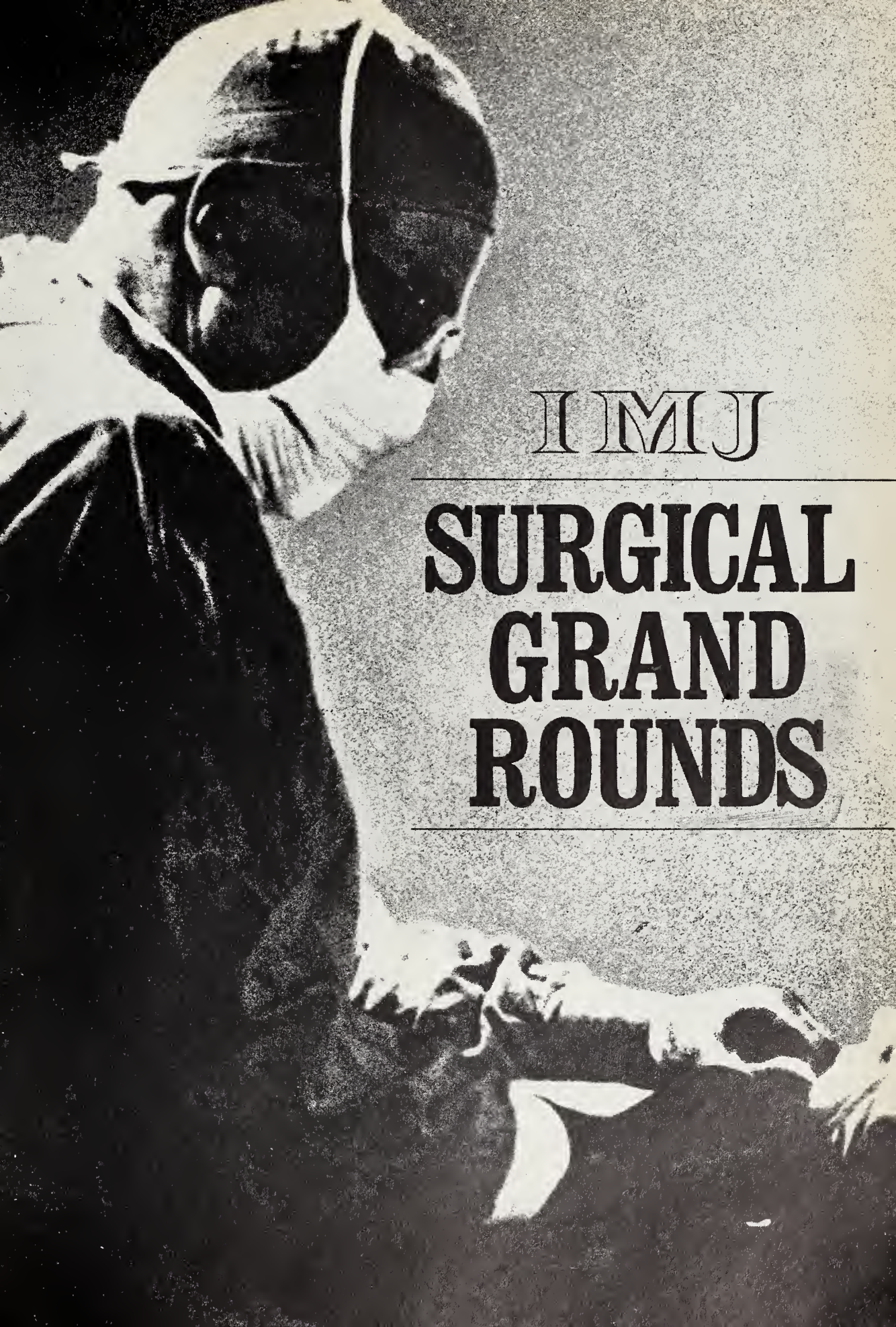
Other specific measures relative to educating the patient to avoid contamination and the staff on disposing of contaminated tissues are spelled out. Good ventilation without recirculation of air is essential for rooms and wards. Ultraviolet installations for areas occupied by tuberculous patients may also be of value. Elaborate isolation procedures are not necessary because the communicability of tuberculosis is sharply reduced after a few days of treatment. Special laundering and dishwashing methods also are discouraged. Masks and gowns are unnecessary and visitors need not be restricted.

Many general hospitals unknowingly admit tuberculous patients and expose the staff to tubercle bacilli during the prediagnostic period. A greater hazard is created when an undetected case is admitted for another disease. These situations will always be with us. An advantage to the treatment of tuberculosis in general hospitals is the accessibility of other services, including a chest surgeon. Furthermore, it enhances the hospital's contribution to community needs.

Unless the plan is accepted, the remaining sanatoria will be forced to become specialty hospitals for the care of those with a variety of respiratory infections. Many general hospitals are now overcrowded and may not wish to expand their facilities. Teaching institutions may welcome the addition for a more complete coverage of important diseases.

T. R. Van Dellen, M.D.





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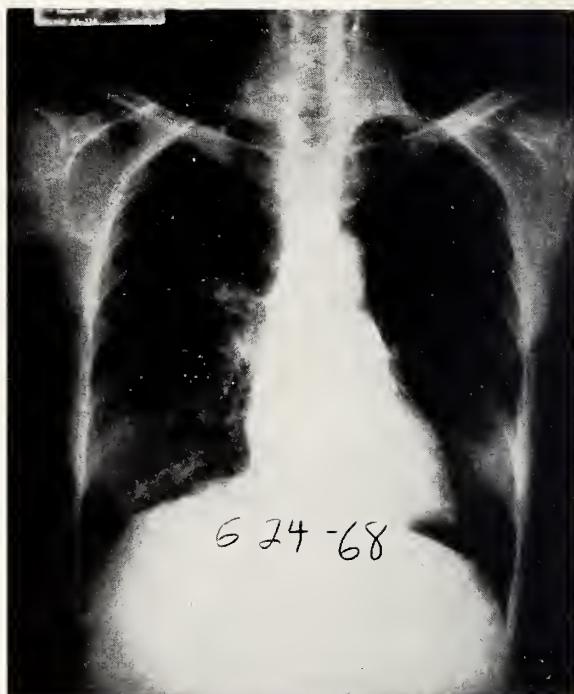
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# **SURGICAL GRAND ROUNDS**

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# *Uterine Tumor*

EDITED BY JOHN M. BEAL, M.D.



**Fig. 1** Chest film nine months before admission revealed right perihilar mass.

*Surgical Grand Rounds are held weekly on Saturday at 8:00 a.m.; alternating between the Staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds held at Passavant Memorial Hospital on March 22, 1969.*



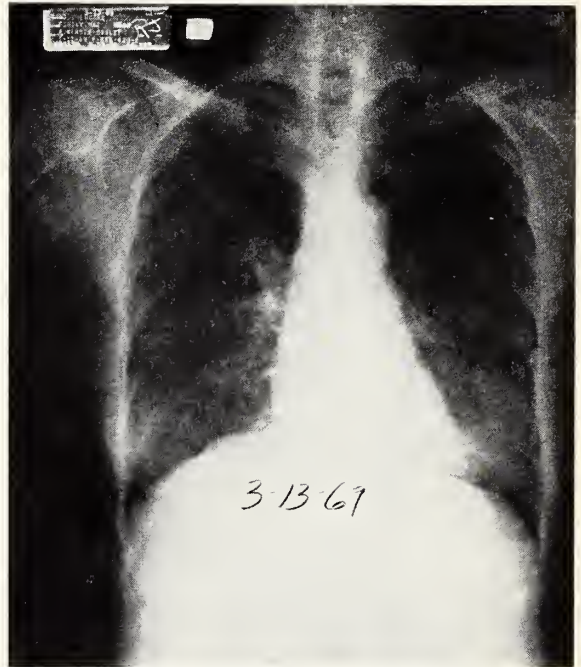
## Case Report

**Dr. Boseley:** A 65-year-old single woman, whose last menstrual period was 20 years ago, entered Passavant Memorial Hospital with the chief complaint of a clear vaginal discharge of three weeks duration. The patient denied pelvic pain or vaginal bleeding. Last pelvic exam one year prior to admission during hospitalization on the medical service was described as normal. During that admission, a right peri-hilar pulmonary lesion had been noted as well as a hemolytic anemia with a positive Comb's test which persisted.

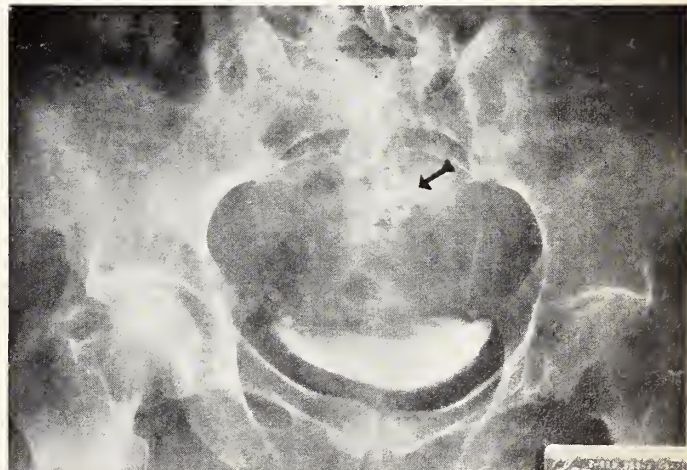
Physical examination at the time of the present admission revealed a pale white female. Positive findings: The edge of the spleen was palpable. Pelvic examination revealed an annular fixed ridge in the vagina two centimeters distal to the cervix. The cervix itself was clean and fixed. The uterus was the size of a 14-week pregnancy and was fixed and irregular. Urinalysis was unremarkable. Hemoglobin was 8 gm. X-rays were obtained. The patient was subjected to a dilatation and curettage, cervical and vaginal biopsy.

**Dr. Michael Murphy:** The chest film taken in 1967 was normal, but a film taken 6 months later showed a right perihilar density (Fig. 1) 2 cm. in diameter. Tomography of this lesion failed to show either cavitation or calcification. During the next six months the lesion completely disappeared, and the most recent chest film again appeared normal (Fig. 2). Complete clearing of this density makes metastatic lung disease very unlikely, but a slowly resolving pneumonia could give this picture. Other studies done on this patient include a normal Barium enema; intravenous pyelogram is normal except for calcifications in a fibroid seen here (Fig. 3).

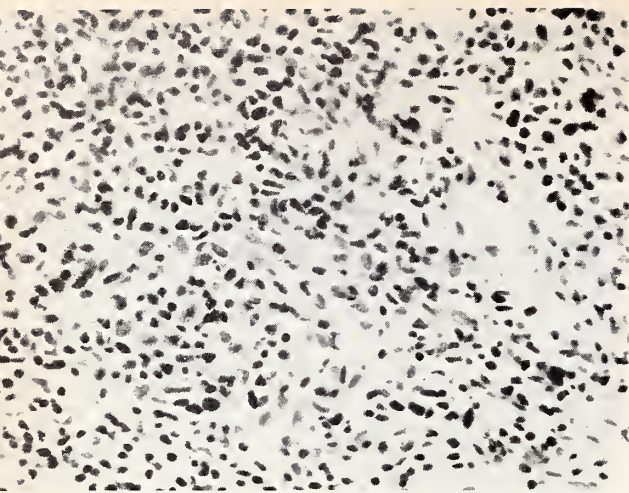
**Dr. Joseph Sherrick:** The material we received were biopsies of the endometrium, endocervix, cervix and vagina. All of these showed similar changes. The normal structures were completely replaced by the peculiar infiltrate seen in Figure 4. This is a mixed infiltrate, the small dark cells being lymphocytes. There are a few spindle-shaped cells and some large cells which look like reticulum cells. Some of the large reticulum cells are bizarre, and resemble those seen in Hodgkin's disease. However,



**Fig. 2** Chest X-ray appeared unremarkable at time of admission to hospital.



**Fig. 3** X-ray of pelvis during intravenous pyelogram demonstrated calcifications in a fibroid.



**Fig. 4** Photomicrograph of endometrial curettings shows infiltrate which was classified as malignant lymphoma of the mixed type.

typical Reed-Sternberg cells were not seen, so we classified this as a malignant lymphoma of the mixed type. I suspect that with more material we might find Reed-Sternberg cells, and be able to make a diagnosis of Hodgkin's disease. A bone marrow done eight months previously was perfectly normal. It is unusual to make the diagnosis of malignant lymphoma from endometrial curettings. The ones we have seen before were in patients who obviously had diffuse malignant lymphoma.

**Dr. Melvin Gerbie:** Of course we turned over the curettings and biopsy specimens to Dr. Sherrick who actually made the diagnosis. The cervical as well as the vaginal biopsies revealed a similar infiltrate and it wasn't just the endometrium. This disease was already outside of the uterus. Four percent of 700 patients with malignant lymphomas clinically had genital involvement. It is found much more often in autopsy studies. Many authors try and separate primary from secondary genital involvement and there's question whether or not this is of real importance, although some authors would recommend a radical surgical procedure for a supposedly primary genital involvement of the uterus or cervix. We as well as most other authors do not think that this is important.

The occurrence of malignant lymphoma in extranodal areas is usually determined by the normal presence of lymphatic tissues in these areas. There is lymphoid tissue in the normal endometrium and although lymphoma is rare in the uterus, it is much more common in the uterus than in the ovary where there is no normal lymphoid tissue. Similarly, 1,000 patients

with testicular tumors were reviewed at the AFIP and there were no primary lymphomas and only occasional metastatic disease. Again is there such a thing as a primary? In addition, it is unusual to make this diagnosis because of the difficulty in histology. Certain uterine stromal sarcomas, undifferentiated carcinomas, and poorly differentiated leiomyosarcomas, have somewhat similar appearances. At Passavant Hospital, a few years ago a patient was reported as having an ovarian granulosa theca cell tumor which originally was reported to be a lymphoma.

Regarding uterine lymphoma there are no distinguishing features which separate it from other rapidly growing uterine tumors. The usual symptoms are bleeding or vaginal discharge. The size of the uterus and the extent of the disease determines the degree of the fixation. In the case being presented there is a note on the chart from the radiotherapist who says this lesion feels similar to the findings of an extensive cervical carcinoma. The diagnosis is made by D&C and cervical biopsies, although an intramural lesion may not produce any symptoms and will not present these findings. The lab data is not particularly helpful unless there's a leukemia present. In our patient there was a finding that on review is probably helpful. This patient had a hemoglobin of eight grams. We thought postoperatively that this patient had endometrial carcinoma or pelvic sarcoma and we decided to give her a blood transfusion before doing the D&C. We could not cross match this patient. Her serum hemolyzed her own red cells and this was probably evidence of a diffuse process. It is common to find case reports in the literature similar to this one where patients had medical workups done for other symptoms and did not really present themselves for definitive diagnosis until they had gynecologic symptoms. Certainly when there's bleeding, the bleeding is investigated and the diagnosis can be made. I've also seen the reverse true. The only other patient I've known where the diagnosis was suspected was one in which a clinician made the diagnosis of pelvic lymphoma because of the multiple nodularity in the fibroids and an antiflexed uterus. A recent series of five adenexal tumors were found to be retroperitoneal lymphomas and



these patients presented to the gynecologist even though they turned out not to have ovarian enlargements.

The treatment depends upon whether you believe this is a multicentric disease or unicentric and this patient will receive radiotherapy and steroids. I'm not really sure that this lesion was missed previously. This lady had fibroids before and she has probably had those for a long period of time. Whether she has had genital lymphoma is hard to say.

**Dr. Beal:** I looked in Dr. Danforth's textbook and failed to find any mention of lymphoma sarcoma of the uterus. This emphasizes the fact that this is a very uncommon lesion.

**Dr. Gerbie:** In 1965 there were 10 cases of primary uterine lymph sarcoma or uterine lymphoma reported. In 1957, Ober and Tovell reviewed the previous reports of uterine lymphoma and rejected most cases as having metastatic disease to the uterus. They did add two cases which fit the requirements for primary disease. Dr. Brewer's book does mention it as an uncommon finding. Whenever there's a lymph cell you can get a lymphoma, and the disease is present in the genital tract in up to 40% of autopsied patients who have lymphoma.

**Dr. Beal:** Do you have any information on the prognosis?

**Dr. Gerbie:** Fox and More reviewed the nine cases of so-called primary uterine lymphoma previously published and added an additional case. Four of these patients died within nine months of the initial diagnosis and the remaining six patients were alive and free of disease for periods ranging from three months to four years.

One patient who died within seven months of the original diagnosis had a 5 cm. reticulum cell sarcoma confined to the cornu of the uterus and no other obvious organ involvement. Although the prognosis would seem relatively favorable for patients with lymphoma only present clinically in the uterus, this is certainly not the usual finding. In the case presented today we do not believe this is a primary uterine lymphoma and offer a very guarded prognosis.

**Dr. Paul O'Brien:** I think this would be an excellent candidate for a lymphangiogram so that the patient's disease could be properly staged. I don't believe that we really have any information to justify surgery. Surgery has not been shown to be any better than radiation therapy in early lymphoma and certainly is not as successful as radiation when the disease is beyond Stage I.

**Dr. Gerbie:** Wouldn't the presence of the hemolytic anemia, palpable spleen and the chest findings suggest a systemic process? A lymphangiogram has been discussed with the radiotherapy service and none is contemplated presently. The patient now has a fixed pelvis and will receive radiotherapy similar to that given for all advanced cervical carcinoma without the use of intracavitary radium. Steroids have been started and chemotherapy may be added later. ◀

## References

1. Fox, H. and More, J. R. S., "Primary Malignant Lymphoma of the Uterus," *J. Clin. Path.*, 18:723, 1965.
2. Ober, W. B. and Tovell, H. M. N., "Malignant Lymphoma of the Uterus," *Bull. Sloan Hosp. Women*, 5:65, 1959.

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## Inflation Should Be No Surprise

"We should not be surprised or dismayed by the difficulties we are now having in bringing inflation under control. An extended inflationary period engenders expectations of further inflation and, therefore, has a major impact on wage and price setting. It also provides an incentive for not postponing buying for consumptive or investment purposes. The resulting continued strong demand helps neutralize the influence of restraining forces at work in the economy."—Robert P. Mayo, Director, Bureau of the Budget.





## THE VIEW BOX

By **LEON LOVE, M.D.**

*Director, Department of Radiology, Loyola University Hospital  
and Chairman, Department of Radiology, Loyola University  
Stritch School of Medicine*

The patient was a 32-year-old female of Puerto Rican extraction who entered the hospital complaining of vague right upper quadrant abdominal pain intermittently present for three years. She had one episode of bloody urine and had been anorexic, and had lost 15 to 20 pounds in the previous six months. Three years prior to this admission she had been told by another physician that she had an "enlarged" right kidney and surgery was advised at that time.

Physical findings were limited to a hard tender right upper quadrant mass which extended from the costal margin to the umbilicus.

What's your diagnosis?



Fig. 1

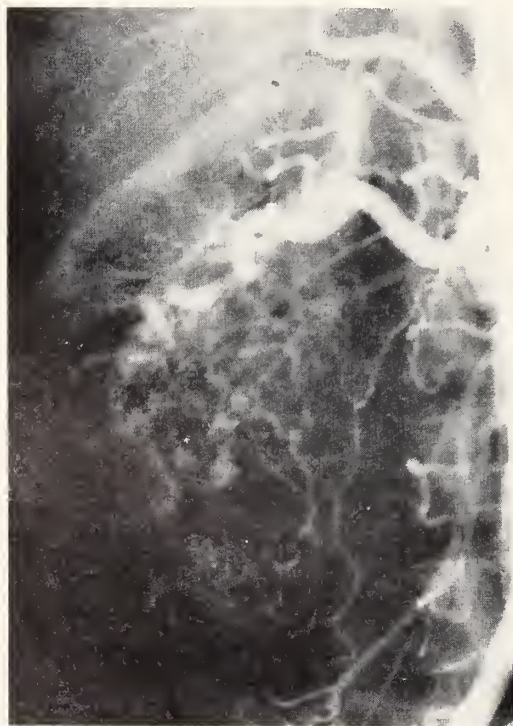


Fig. 2

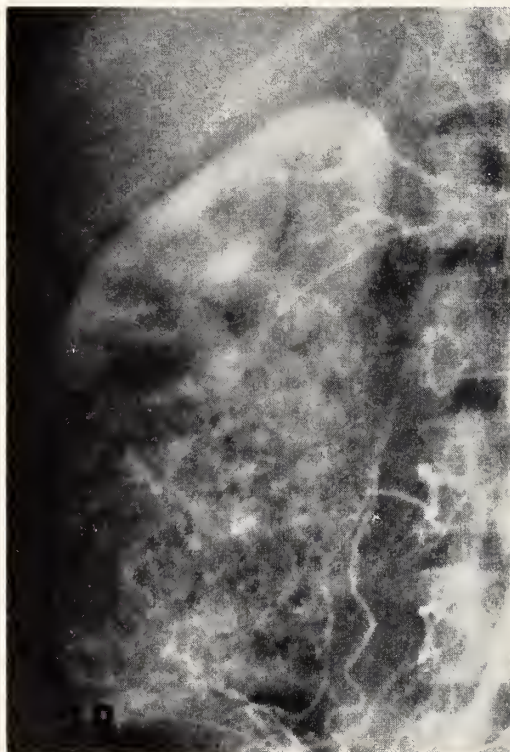


Fig. 3

(Answer on page 748)

# Pitfalls In The Diagnosis Of Venous Thrombosis\*

By GEZA DE TAKATS, M.D./SKOKIE

*There are silent, spreading, migrating and embolizing thrombi and there are also non-thrombi mistaken for thrombi and intensively treated. This paper will limit itself, however, to the discussion of some basic physiologic phenomena which favor thrombosis, localize thrombosis, fragment or lyse thrombosis all in the lower extremities and pelvis; prevention and management.*

## The Clinical Picture

One can readily recognize acute, chronic and recurrent thromboses. But one should also consider silent or latent forms of thrombosis which escape detection either because one does not look for them, because they migrate when embolism occurs, or because they are truly undetectable. This is particularly true of what I call plexus thromboses where the presence of a clot does not significantly disturb venous return, nor does it set up an inflammatory, periphlebitic reaction. Plantar, calf muscle and adductor plexus thromboses are examples of this group.

Let us start with the easiest and most readily recognizable *superficial phlebitis*. Segments of previously normal or enlarged saphenous vein close with or without a periphlebitic reaction and may ascend toward the groin. When the affected veins are collaterals to an old deep venous obstruction or insufficiency, more edema or systemic reaction occur, since these veins may represent functioning collateral channels. It is safe to say that primary venous insufficiency of the saphenous system is more the exception than the rule and that most patients have had a deep or perforator vein thrombosis preceding the appearance of superficial varicosities.

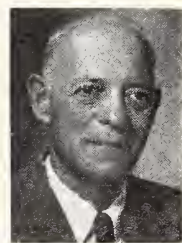
Traumatic superficial phlebitis and catheter phlebitis which is due partly to trauma and partly to infection are known entities. Phlebitis in previously uninvolved superficial veins is suspicious of thromboangiitis obliterans, hypersensitivity vasculitis, lupus, gout or cancer of hidden origin.

*Plantar vein thrombosis* is characterized by numbness, cramping and pain on pressure on the bottom of the foot, especially on the lateral side. A little later the posterior tibial vein, which drains this area, may become tender and a slight pitting edema fills out the hollow area at the medial malleolus. The process may stop here and result in atypical patterns of varicosities coursing over the Achilles tendon and involving the submalleolar space on the lateral side. Sometimes these collateral veins thrombose and lead to exotic orthopedic diagnoses.

*Calf muscle thrombosis* may originate in the plantar plexus or start in the large network of veins under the deep fascia. Even before swelling occurs, the skin becomes warmer and the muscles show guard-

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\*This paper was presented at the 22nd Annual Clinical Convention of the American Medical Association, Miami Beach, Florida, December 2, 1968.



ing with pain on pressure. Pain also develops on dorsiflexion of the foot, but this Homans' sign is negative in about half of the cases. Conversely, a positive Homans' sign can be elicited in patients whose muscle spasm is due to nerve irritation from the lumbosacral level. Using a blood pressure cuff around the suspected calf, a pressure of 60-100 millimeters of mercury causes pain on the affected side, whereas the normal, opposite calf will stand a pressure of 160-200 millimeters of mercury before pain develops. *No edema appears* until one of the main channels or the popliteal vein itself becomes involved.

*Adductor plexus thrombosis* is seldom diagnosed unless one looks for it. There is a palpable spasm and pain on pressure of the adductor muscles, but no swelling unless the clot ascends through the profunda to the common femoral vein, or if the inguinal lymph glands enlarge. Quite recently I saw a patient suffering from pulmonary embolism with no leg signs but an adductor muscle spasm. On inguinal exploration, a clot could be aspirated through the profunda femoris.

*Pelvic Plexus Thrombosis.* The clot may originate in the large perirectal, periuterine, periprostic and perivesical plexuses. The number of phleboliths seen in pelvic Roentgen films attests to their frequency. These clots are mostly silent although dysuria, rectal spasm or minimal vaginal or prepubic swelling may be present. They become manifest when a cord becomes palpable at the site of the tubo-ovarian veins or the parametrium becomes infiltrated. The diagnosis is hardly tenable or certain until the hypogastric or common iliac vein is involved at which time high thigh, lumbosacral or gluteal edema appears.

What is the value of phlebograms in such a situation? Most large vascular services, including ours, have explored this diagnostic measure long ago, only to find that Roentgen ray visualization of these plexuses is difficult and interpretation of the films is fraught with error. It is impossible to fill such a vast network completely and even if segmental clots are found they may be silent, quiescent and have been there a long time. Calf muscle thrombosis is so frequent that over the age of 50, half of the cadavers dissected for this purpose have it.

*Suppurative pelvis thrombophlebitis* follows abortions, infected child births and laparotomies. A septic type of temperature, chills and intermittent bacteremia which does not always yield a positive blood culture are present. This is a true periphlebitis and lymphangiitis which often leads to enlarged inguinal lymph glands from where a positive culture may be obtained even when blood cultures fail.

*Popliteal Venous Thrombosis.* While an acute or repeated chronic trauma of the soleus tendon may be responsible for some popliteal vein occlusions, the majority of such thrombi ascend from the calf muscles and a careful history may elicit calf muscle tenderness, cramping or "charlie-horse" preceding the sudden cyanosis and huge edema when the femoro-popliteal segment is occluded. Thrombosis at such a level will invariably result in troublesome sequelae and therefore every effort should be made to treat the early calf muscle thrombus before it reaches this level. The clot may permanently occlude this segment with the appearance of huge collaterals or recanalize with a valvular incompetence at which time retrograde venous flow in the sitting or standing position will be the problem. The thigh remains uninvolved, but a huge ballooned-out calf will result with incompetence of many perforators, notably that of the short saphenous vein.

*Iliofemoral Venous Thrombosis.* It may well be as Aschoff originally suggested that the inguinal ligament creates a frequently recurrent venous stasis accounting for thromboses at this level. But a more frequent cause of this localization is the fact that this segment constitutes a bottleneck into which the saphenous, superficial and deep femoral veins and all of the pelvic veins drain. In addition, the proximity of a large number of lymph glands, often chronically inflamed from sources in the toes, leads to a periphlebitic lymphedema so that the patient now has the *large, white milkleg*, phlegmasia alba dolens. If on top of all this, there is massive distal and proximal venous thrombosis extending into terminal veins, phlegmasia cerulea dolens, the blue phlebitis may develop which may lead to gangrenous toes, feet or massive skin infarcts. None of this happens at once, and early intensive treatment does prevent these



later sequelae.

There are other predisposing factors in the iliofemoral venous segment which favor thrombosis at this level. The enlarged or tortuous right iliac artery compresses or displaces the left common iliac vein; there are congenital septa and often some unrecognized mural thrombi which produce a narrowing of this segment. Large retroperitoneal masses or lymph glands may press on it. A bilateral iliofemoral phlebogram is the most revealing and direct evidence of involvement at this level.

Finally, partially or totally occlusive thrombosis of the *vena cava* may give little evidence of swelling unless thrombosis distal to this level is present. Recently, a patient was observed with a renal vein thrombosis which extended into the *vena cava* and gave rise to multiple emboli. Aortic aneurysms sometimes compress and occlude the *vena cava* or even establish an arteriovenous fistula which is then characterized by a palpable pulsating mass, massive edema of the extremities and progressive heart failure.

### The Diagnosis

I shall not dwell on the obvious clinical signs and symptoms of venous obstruction, perivenous inflammation, tenderness on palpation and defensive muscle spasm. I would much rather dwell on the silent or latent clots which are first looked for when pulmonary embolism occurs. These sit mostly in the venous plexuses, do not cause obstruction to flow, do not set up a periphlebitis and may not be painful. About 60% of pulmonary emboli occur in the absence of leg signs.<sup>1</sup> The hardest ones to diagnose are the traumatic thromboses occurring after a fractured hip or tibia, because of the hemorrhage and swelling accompanying these fractures.

Exercising the suspected limb under a venous tourniquet does bring out unsuspected collaterals. There is no need to take venous pressure measurements and the phlebograms of the plexus thromboses are often deceptive. A slight increase in skin temperature or filling of dorsal veins in the dependent position is worth more than eight serial phlebograms. The real difficulty is that even if you detect a segmental venous occlusion in the calf *you don't know how long it has been there* and

whether it has anything to do with the present problem.

The *color* of the suspected leg may be slightly cyanotic in the dependent position, but if vasospasm is present, the limb is cooler and paler. Twenty, thirty years ago much was written and said about paravertebral sympathetic blocks in venous thrombosis. Today, speaking for myself, they are hardly ever done, first because heparinization is such an urgent and effective measure, and secondly, because only a small percentage of patients exhibit vasospasm. It probably has to do with direct lymphatic involvement of sympathetic fibers, the amount of pain and the superimposed anxiety. If such blocks are done they *must precede heparinization*.

*Laboratory Aids.* An increased sedimentation rate, elevated white count with a differential shift to the left simply means an inflammatory state but nothing specific for phlebitis. A high red cell count, a high hematocrit, dehydration because diarrhea or diuresis do predispose to clotting and their presence would strengthen a suspicion of thrombosis. A hypercoagulable state, i.e., a demonstrable tendency to increased clotting does exist in patients with carcinomatosis, polycythemia, thrombocytosis and in shock-like states. But it should be emphasized that the presence of a hypercoagulable state alone is not equivalent to thrombosis. One or two factors, as emphasized by Virchow in 1829, namely, stasis and an injured vessel wall must be present before an increased clotting tendency really produces thrombosis. Stasis in the plexus veins is a potent factor. A break in the smooth venous endothelium allows platelets to adhere to the collagen in the vessel wall, but it also prevents the release of a fibrinolytic factor, since most normal individuals have a remarkable ability to dissolve their own clots. This fibrinolytic potential seems to be deficient in patients with manifest thrombosis and we have developed a simple clinical test to measure it.<sup>2</sup>

### Differential Diagnosis

I have already spoken of the frequency with which silent or subclinical thrombi are missed. But the opposite is also true. There are a whole set of clinical entities which are mistaken for venous thrombosis and zealously treated when unnecessary.

*Acute lymphangitis* with lymphedema is frequently mistaken for thrombophlebitis. There is usually a detectable port of entry through a fissure in the digits, some infectious process and possibly a history of previous episodes introduced by a chill, malaise, high fever and red streaks or an erysipeloid rash. The regional lymph glands are enlarged, but this also occurs secondary to a venous occlusion.

*Ruptured muscle* "pulled muscle," "charley-horse" consists of a partial tear of the gastrocnemius' plantaris, adductor or quadriceps muscle, usually at the musculotendinous junction. The onset is sudden with excruciating pain on sudden exertion followed by swelling and pain on stretching the muscle. A few days later, a subcutaneous hematoma occurs, distal to the site of rupture, such as at the inner malleolus. A gap may be felt between the retracted muscle and the tendon. Obviously, a ruptured muscle may initiate a thrombus in the muscle vein, which then can extend into the deep veins.

*Cardiac or renal edema* may produce swelling in the extremities, particularly in the lower ones. Evidence of cardiac or renal involvement needs to be established. There is no reason, however, why a superimposed phlebitis could not develop in an edematous extremity and this does happen in both the arms and legs. The slowing venous return and increased venous pressure favor such a complication.

*Saphenous Neuritis.* Patients who have gone through an attack of deep venous thrombosis, following trauma, childbirth or operation, naturally dread a recurrence. They also have a scar around the once-occluded common femoral vein, which envelops the saphenous nerve. After changes in weather, undue exertion or holiday festivities, a mild segmental ache develops from groin to inner ankle with a sensitive pressure point just above the knee where the nerve becomes superficial. Through their past experience, aided and abetted by well-intentioned medical admonitions, such patients develop thrombophobia, which then aggravates their symptoms. Salicylates and reassurance are specific.

*Radiculitis, reflex sciatica, meralgia parasthetica* are some of the instances of painful radiation from the back or greater trochanter, which may give rise to the erroneous diagnosis of phlebitis. Especially

in patients in whom the pain radiates to the periphery along the sciatic nerve; the Homans dorsiflexion sign becomes positive, the calf muscles are tender and tight and often some vasospasm producing cooler skin appears. Detecting some painful trigger zones in the back and reproducing the patient's complaints by various movements of the back and by the leg-raising test readily differentiate these conditions from phlebitis.

*Arthritis and bursitis* do produce reflex muscle spasm. Arthritis of the knee often exhibits a painful calf muscle; a popliteal bursa presses on the popliteal nerve causing paresthesias clear down to the heel.

*Aneurysms, arteriovenous fistulas.* By compressing veins and nerves and often by actually producing thrombosis, these lesions require careful differentiation from the usual types of phlebitis. Arteriovenous fistulas, especially the congenital ones, exhibit large tortuous varicosities, which frequently develop into acute phlebitis. In case of doubt, aspiration of such a vein with a 25- or 26-gauge needle will produce a drop of blood which is red and well oxygenated; in contrast, blood from a varicose vein due to valvular incompetence is dark blue and poorly oxygenated. Sometimes a chronic phlebitis may produce arteriolar-venular shunting and the blood will appear oxygenated.

### Course of Thrombosis

The course of venous thrombosis is unpredictable. A small segmental clot may lyse, organize, recanalize, grow by apposition or break loose. The factors that are responsible for the variable sequence of events are only partially known, not readily recognized and not always controllable. Because of this, an evaluation of therapeutic measures is difficult, since natural defenses of the body are activated.

*Lysis.* There is incontrovertible evidence that a venous clot may be completely dissolved by the body's fibrinolytic system. This occurs day after day in the microcirculation, but even large clots can be lysed. There is angiographic evidence for this. The recent soft clot responds better to profibrinolysin activators than a hard, partially organized clot. The older the clot, the less it is apt to dissolve.

*Organization.* Fibrin and fibroblasts grow into the clot turning it into fibrous tissue



with some contraction, so that small channels shortly develop which, in turn, do not function as effective conduits.

**Recanalization.** The overwhelming number of clots in the major pathways, such as the superior and inferior vena cava, the iliofemoral, popliteal and subclavian-axillary segments, recanalize to a certain degree, turning the vein into a hard, fibrous channel and destroying the valves, so that a valvular incompetence, a venous regurgitation, develops. This is responsible for the postphlebitic varicose veins, where a venous reflux develops through the deep veins and the communicating veins into the two saphenous systems. This is the cause of varicosities in the lower extremities in the vast majority of cases, although some occluded segments do remain permanently closed.

**Growth by apposition.** When a clot develops in a certain segment of the venous system, it may grow proximally or distally, depending on the presence of collateral veins, on the rate of flow in blind segments, on the clotting mechanism and on the state of the endothelial lining. The clot may grow to the site of the next tributary, where venous return becomes adequate. It can also grow proximally to a venous ligature, unless precautions are taken to prevent it.

**Embolus.** The soft red-cell thrombus, developing on top of a platelet or fibrin thrombus, may readily break loose and appear as a pulmonary embolus. Straining on the bedpan or getting out of bed the first time after an operation have been repeatedly incriminated, but many more patients develop pulmonary emboli in bed at night or sitting quietly in a chair. The enzymatic processes that loosen the clot from the intima or separate a floating tail from the well-adherent head of a white thrombus are poorly understood. Many—over one-half—of pulmonary emboli occur from so-called “silent” thrombi, which cause no clinical symptoms until days after the embolization.

### Sequelae

**The postphlebitic syndrome.** A thrombus in a large vein such as the iliofemoral or popliteal segment recanalizes and becomes patent. While it does occur, a permanent thrombotic occlusion in a major vein of the lower extremity is rare. Instead,

a deep venous insufficiency develops due to the destruction of competent venous valves by the organizing and then recanalizing clot.

This results in a high venous pressure in the deep venous system in the standing and sitting positions. Gradually, more and more previously competent valves open up in the communicating and saphenous veins, until the entire venous system is valveless. This results in tense, tortuous varicosities, increasing edema, recurring bouts of phlebitis, fibrosis and fat necrosis, localized patches of induration, dermatitis and finally the postphlebitic ulcer.

Under the ulcer there is usually a large incompetent perforator vein; surrounding the ulcer there is inflamed, indurated scarring with lymph stasis, which has a way of spreading toward the knee.

Superimposed mixed infection, allergic dermatitis due to local use of antibiotics, and arteriolar disease due to intense fibrosis and work-hypertrophy of the arterioles complicate the picture. The venous hypertension is responsible for a veno-arteriolar reflux constricting the precapillary sphincters—and thus trying to maintain a normal capillary pressure. All these factors will have to be considered when treatment is discussed.

**Pulmonary embolism.**<sup>5</sup> The incidence of this complication is difficult to state, since so many small emboli are asymptomatic. Emboli may come from the right side of the heart or even from the left side, if the foramen ovale is patent. Nevertheless, the majority come from the area drained by the inferior vena cava, with a few coming from the upper extremity, notably the subclavian-innominate segment.

The symptoms and signs of a pulmonary embolus consist of a vague malaise, rise in pulse and temperature, a sudden stitch in the side (mistaken for pleurisy), retrosternal pain with pallor and fall in blood pressure (mistaken for coronary thrombosis), hemoptysis (mistaken for pneumonia), chills and fever (mistaken for atelectasis or pneumonia) and shift of the mediastinum (mistaken for atelectasis).

The white-cell count and the sedimentation rate rise, which is certainly not specific. The clotting time and prothrombin time shorten and later lengthen. The SGOT (serum glutamic oxalactic trans-



minase) remains normal, but the SLD (serum lactic dehydrogenase) rises together with the serum bilirubin. The absence of this triad of tests, often unavailable in smaller hospitals, need not make the clinician unhappy.

X-rays of the chest will show a shadow—certainly seldom the classic triangle with its apex at the hilus—about the fourth day. Before that, the diaphragm may rise and the rib spaces narrow, as a form of protective splint. Because of a reflex bronchospasm and bronchial secretion, translucent areas of emphysema may appear as evidence of bronchostenosis. In carefully studied postmortem material, 60% of the cadavers showed pulmonary emboli.

The cardiogram may show a typical cor pulmonale due to a rise in pressure in the pulmonary artery, but this is not specific. Many years ago Carl Fenn and I showed, experimentally and clinically, that the cardiogram following pulmonary embolism may be indistinguishable from that following coronary thrombosis. However, since much of it is due to reflux effects, the return of the cardiogram toward the normal pattern is faster.

### Special Patterns

*Shelter Legs.* First described during the London blitz, when large numbers of people spent hours in a cramped position and emerged from the shelters with painful edematous legs, this picture is seen now after long plane or automobile rides. In the presence of pre-existing varicosities, thromboembolism is encountered. The lesion is a combination of venous and lymphatic stasis and is aggravated by the tight panty-girdle, by heat and alcoholic vasodilation.

*Bartender's Legs.* The combination of prolonged standing, chronic consumption of alcohol with a poor nutritional state, hypoproteinemia and increased capillary fragility produces almost intractable lesions of the venous and lymphatic system with dermatitis, ulceration and self-medication causing local and generalized allergic eruption. Only change of occupation can help.

*Christmas Phlebitis.* Young housewives with insufficient help suffer from a venous insufficiency with recurrent attacks of phlebitis frequently activated at holiday time with influx of critical mothers-in-law,

standing up at cocktail parties, insufficient sleep and consumption of heavy food and spirits. Weight and blood cholesterol rise, clotting tendency, stasis and neurogenic dermatitis increase.

*Catheter Phlebitis.* Indwelling catheters are now widely used in patients receiving fluids, nutrition or cardiopulmonary studies. In one recent study, 39% of catheterizations resulted in phlebitis; half of these catheters removed from phlebitic veins showed positive cultures and one third of all catheters were positive by culture whether there was a manifest phlebitis or not. Worse than that, 2% of all catheterized patients developed bacteremia and one percent died.<sup>3</sup> At our hospital Bentley and Lepper arrived at similar figures. Of 44 septicemias in 1966, 19 (43%) were related to this port of entry. Daily observation and early removal of the catheter were means of prevention. Significantly, while only 10% of the catheters were placed by the house staff, 90% of the phlebitides occurred in this group.<sup>4</sup>

*Smoker's Phlebitis.* Heavy smokers, men but also women, develop segmental migrating phlebitis of superficial veins. Such people should be studied for the presence of thromboangiitis obliterans which is an allergic vasculitis, or for a hidden carcinoma of the lung, pancreas, ovary or colon. Not only is fibrinogen high in the blood, but there is hemoconcentration and increased blood viscosity.

*Pill Pleurisy.* This 38-year-old, buxom housewife with three children starts taking the Pill at the request of her husband, but reluctantly. Two months later she develops a sudden attack of pleurisy with shoulder pain. The chest is strapped and the symptoms slowly subside. Next she has an agonizing chest pain in the middle of the night, diagnosed as angina by her husband, whose father had it. Cardiograms are negative and much reassurance is given. A week later a right-side deep venous thrombosis appears. On weight reduction, low cholesterol diet and tubal ligation, she is left with a postphlebotic syndrome but no further thromboembolic phenomena.

*Thrombophobia.* This young neurotic lady, slightly anemic, more intellectual than her husband had an aunt die of pulmonary embolism. She herself has a number of spider bursts which have been injected

under magnification and had drawing pains mostly in the back and left leg aggravated by changes in weather and before menstruation. She transmits to the physician her anxiety about thrombosis, who places her on dicoumarol and gives her a list of sedatives, tranquilizers and muscle relaxants. Because most of these counteract the action of the anticoagulant, she ends up with a calf muscle hematoma.

**Postphlebitic Causalgia.** This painful vasomotor phenomenon occurs mostly in women with an unstable vasomotor system. The phlebitic leg is cold, painful, sometimes mottled, but does not need to be swollen. A sympathetic block or nitroglycerin demonstrably abolishes the temperature difference between the two legs and gives relief. The trigger zone for this chronic vasospasm may be in pelvic veins, in the femoral sheath or in a short segment of periphlebitis. Thrombophobia is often aggravated by bouts of pain. Periods of physical or emotional stress, changes in barometric pressure or humidity influence the picture. Compensation neurosis may be involved. When phlebitis complicates root pain following disc surgery, cordotomy is the only answer.

**Saphenous Neuralgia.** Periphlebitis in the femoral sheath or along the saphenous nerve may readily catch the saphenous nerve and produce intermittent attacks of pain, panic and thrombophobia.

**Granny's Ulcer.** This middle-aged, sprightly grandmother develops a left-sided iliofemoral thrombosis after her second childbirth. Large saphenous varicosities develop which are insufficiently cared for by occasional sclerosing injections. Gradually a postphlebitic induration appears over the internal ankle. While babysitting for her daughter, the grandson digs his heel into the phlebitic leg while sitting on granny's lap and a chronic ulcer develops.

### Discussion

Pulmonary embolism without leg signs is the greatest challenge to find a *silent thrombus*. Some men tie, plicate or use a sieve to obstruct the vena cava without being sure that there is a thrombus distally. Others, including ourselves, believe in subtle clinical signs and symptoms together with a phlebogram of the iliofemoral and caval segments to establish the diagnosis.

When the clot is obvious and spreading, intensive heparin therapy with or without proximal ligation or clipping is mandatory. The clot sometimes spreads or recurs so rapidly that a hypercoagulable state together with an exhausted fibrinolysis must be assumed and this can be looked for in the laboratory. Many times the patient can fragment and lyse the clot himself even in the pulmonary arterial tree and serial angiograms can demonstrate this. Surgical intervention in the forms of thrombectomy, caval plication and embolectomy should be done in conjunction with the help of methods favoring thrombolysis.

### Summary

The triad of Virchow, stated in 1829, i.e., slowing of venous return, hypercoagulability of the blood and reaction of the venous endothelium are still the three important factors in the production of venous thrombosis. Neither of these factors alone is capable of producing a manifest clot. In searching for the involvement of venous plexuses, their collecting veins and minor embolic phenomena, one can often recognize incipient thrombosis and treat it with its specific antidote, heparin. The recognition of a hypercoagulable state and the patient's ability to dissolve his own clot are determinants of the future course. Finally, the impairment of the intact lining of the vein occurring in inflammatory and allergic diseases needs to be considered. Attention is drawn to typical clinical pictures such as shelter legs, bartender's legs, Christmas phlebitis, pill pleurisy, granny's ulcer and some others which are preventable when anticipated. ◀

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# Rubella

FROM THE AMA COUNCIL ON ENVIRONMENTAL AND PUBLIC HEALTH

While rubella (German Measles) is generally a mild disease when contracted during childhood, in postpubertal individuals, particularly females, there is considerably greater potential for harm. The illness is often more serious and prolonged and not infrequently has complications such as arthritis, arthralgia, and rarely, encephalitis. In addition, when rubella is present during pregnancy, especially during the first trimester of pregnancy, but also during the second trimester, from 15% to 35% of the infants may be born with what is now known as the congenital rubella syndrome. This includes partial or total loss of hearing or vision, major heart defects, mental retardation or combinations of these defects. In addition, there is a significantly increased proportion of miscarriages and stillbirths. Thus, serious transplacental damage is done by the virus.

The incidence of rubella shows a seasonal increase in the spring, generally during March, April, and May, in the United States, and these seasonal increases, in turn, have superimposed on them major national and international epidemics occurring at irregular intervals of from approximately six to nine years each. During the last forty years, there were three exceptionally high pandemic peaks that occurred about 1934 and 1935, 1942 and 1943, and 1964.

The primary goal of rubella vaccination is the prevention of the congenital rubella syndrome, with secondary goals of preventing rubella in postpubertal patients where disabilities are usually more serious than the relatively mild disease that it causes in young children.

## Vaccine Development

In June, 1969, the first rubella vaccine was licensed in the United States. This was an attenuated live virus, made from

the HPV-77 strain that has been grown on duck embryo cell culture. This vaccine was tested on over 13,000 susceptible children prior to licensing, with essentially no adverse reactions, although transient arthralgia or arthritis and rash did occasionally occur in older patients.

Currently an attenuated live virus rubella vaccine from a different strain (Cendehill) is being manufactured. This is grown on rabbit kidney cell culture in Belgium and probably will be licensed in the near future in the United States. There is a similar expectation for an attenuated live virus vaccine that has been grown on dog-kidney cell culture. In addition, experimental work is progressing with a still different virus strain (WI-38), which is being grown on human embryo lung cell culture (Diploid cell). Thus, it is very likely that prior to the next seasonal peak, which would be anticipated in spring, 1970, millions of doses of at least three different rubella vaccines will be available for use in the United States.

## Vaccine Administration

The currently licensed vaccine is administered by a single subcutaneous injection of reconstituted lyophilized vaccine. The label and insert instructions should be carefully read and followed. The following precautions are recommended.

***Pregnant women must not be given the vaccine*** because the viremia that follows vaccination and lasts two to six weeks may permit the virus to pass the placental barrier and affect the growing fetus.

If vaccination of a nonpregnant woman in the childbearing age is anticipated, special safeguards should be taken. These might include testing the woman to make sure she is not already immune to rubella and would include carefully weighing the



advantages of vaccine administration against the disadvantages, including the possibility of her becoming pregnant, with the likelihood that the fetus might miscarry or develop the congenital rubella syndrome. If the physician believes that vaccination is desirable, he should prescribe a medically acceptable method for contraception and should explain the potential risk of becoming pregnant to the patient, and, preferably, obtain written, informed consent for the vaccination.

Because of the possibility of placental transfer of maternal immune bodies and the likelihood of these interfering with the development of immunity following vaccination, it is recommended that the vaccine not be administered to children under one year of age. The presence of other virus diseases or any febrile active generalized infection, as well as the use of corticosteroids, irradiation, alkylating agents or antimetabolites or other agents that would weaken the normal defense mechanisms of the individual are contraindications to the use of rubella vaccine. Other contraindications include concurrent use of a different live virus vaccine (eg. measles or poliomyelitis). Administration of the rubella vaccine should then be deferred for at least four to six weeks.

### **General Recommendations**

Inasmuch as the vaccine currently available in the United States is still relatively new (about 13,000 susceptible children had been observed for adverse reactions prior to licensing), it is possible that unanticipated adverse reactions, particularly in older patients, may occur with the general use of the vaccine. Therefore, it is recommended that any serious adverse reactions be reported promptly to the State Health Department and to the manufacturer who is responsible for reporting it to the Division of Biologic Standards of

the National Institutes of Health.

While the frequency of naturally acquired immunity varies considerably with the age of the patient and the incidence and prevalence of the disease in a particular community, the National Communicable Disease Center estimates that about 15% of the children under five years of age have become immune through naturally acquired disease, and that for the other age groups the respective natural immunity levels are approximately 35% for the five to nine year olds, 60% for the ten to fourteen year olds, 75% for the fifteen to nineteen year olds, and 85% to 90% for those twenty to thirty-nine years old.

These figures vary from community to community, but may be used as a general guide for the desirability of performing screening tests for susceptibility prior to giving the vaccine. However, each person should be evaluated on an individual basis whenever possible.

For widespread use, in view of the lack of adverse reactions in small children and the fact that about two-thirds of the children under ten would be susceptible, all should receive the vaccine without doing a preliminary serological test for susceptibility. Children in kindergarten and the early grades of elementary school deserve initial priority for vaccination because they are commonly the major source of virus dissemination in the community. A history of rubella illness is usually not reliable enough to exclude children from immunization.

In view of the fact that circumstances will differ in various localities, it is recommended that group programs and public health programs should be launched on the basis of a coordinated plan, developed jointly by state and local public health agencies in cooperation with state and local medical and osteopathic associations.

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## ***U. of I. Makes Plans to Increase Physicians in Illinois***

The University of Illinois College of Medicine is in the midst of an extensive reorganization program designed to help increase the number of doctors in Illinois. The College of Medicine plans to more than double its enrollment by 1980 through the creation of new clinical schools at hospitals in the Chicago area and in several northern Illinois cities: Rockford, Peoria, Decatur, Moline-Rock Island and Urbana-Champaign.

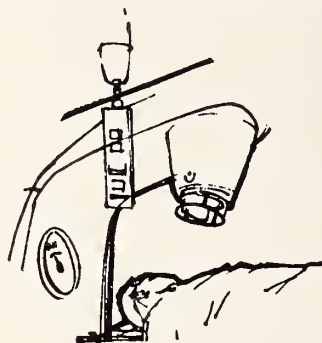
# The Ureter

## *In Health And Disease*

**Fig. 1a. Agenesis of Kidney:** Retrograde pyelogram reveals normal renal structure on one side, and marked irregularity and dilatation of lower ureter on opposite side. No renal structure is visualized above the pathological ureter.



### *Medical Progress*



HARVEY KRAVITZ, M.D.  
Medical Progress Editor

*Formerly relegated to obscurity and considered a renal satellite, the ureter has only recently come into its own as an organ of relatively major import. Not only is a good kidney dependent on a good ureter, but the very existence of the former depends on the existence of the latter. As stated in the preface of my book, THE URETER,<sup>1</sup> "The ureter is to the kidney what the aorta is to the heart."*

Embryologically, the ureter derives as an offshoot of the ureteric or wolffian bud, which in turn unites with the metanephric blastema to form the renal-ureteral unit. If the ureter does not meet the nephrogenic mass, agenesis of the involved kidney results. (Fig. 1—A and B) A poor union produces various anomalies such as polycystic kidneys (Fig. 2) or hypoplastic kidneys. If the ureter changes its course, various anomalies of position such as sacral kidney (Fig. 3) and crossed renal ectopia (Fig. 4) may result.

The sacral kidney must be differentiated from renal ptosis. The anomaly has a very short ureter, while the ureter of the ptotic kidney is of normal length.



**Fig. 1b.** Angiographic study reveals absence of kidney above pathological ureter. Only one renal artery is present, proving non-development of kidney on affected side.

It is important to consider these anomalies in the differential diagnosis of abdominal masses. Anomalies of position may result in the mistaken diagnosis of colonic tumors, ovarian tumors, uterine fibroids, or retroperitoneal neoplasms. Recently, several articles have appeared in the gynecological literature on the consideration of the sacral kidney in the differential diagnosis of pelvic masses.<sup>2</sup>

### Abnormal Embryology

Abnormal embryology in other organs may involve the ureter. A prime example is the failure of the three cardinal veins to properly form one inferior vena cava. The ureter, usually the right, is caught behind the right lateral cardinal vein, and hydronephrosis results. Medial ureteral deviation at the third lumbar vertebra suggests the diagnosis. This condition is known as "Retrocaval Ureter." (Fig. 5), and must be surgically treated.

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As stated by Velardo,<sup>3</sup> histologically, the ureter displays morphologic plasticity, physiologic accommodation, and significant change under different types of stress, obstruction, and aging. Stein and Weinberg<sup>4</sup> noted that ureters vary in normal histology according to age, and that adult ureters contain a much larger percentage of muscle than do newborn ureters. They further determined that the amount of fibrous tissue in the muscle increases as a result of obstruction. These facts are of importance in noting the differences in immediate response to both acute and chronic obstruction of the ureter in different ages. A child's ureter dilates much faster and much larger, proportionately, than that of the adult. The ureter may enlarge to such an extent as to simulate the large bowel in size and contour. (Fig. 6)

In considering the applied anatomy of the ureter, it is important to realize that bilaterally it comes in contact with practically all abdominal and pelvic viscera as it descends from the kidney to the bladder. Consequently, any inflammation or involvement of this organ can mimic symptoms of these other viscera.

**Fig. 2. Polycystic Renal Disease: Classical renal structure of bilateral polycystic renal disease.**







**Fig. 3. Sacral Kidney:** Normally positioned kidney on one side, and pelvic or sacral kidney on the other side. Note very short ureter of anomalous kidney.

The true ureter, embryologically, encompasses the renal pelvis and calyces, and any disturbance of this collecting system involves the secretory portion of the kidney. In the development of the kidney, dependent as shown on ureteral embryology, fetal urine is an important addition to the amniotic fluid. If bilateral renal agenesis is present, the renal filtering unit is interfered with, and oligohydramnios may result.

The ureter normally propels urine due to the stretch of the ureteral smooth muscle by the bolus of the urine as it leaves



**Fig. 4. Crossed Renal Ectopia:** Note both lower ureters in normal position. Crossover occurs higher up.

the kidney. How this actually occurs is still not definite, and no known drug has been proven clinically to either stimulate, or block ureteral peristalsis. Boyarsky<sup>5</sup> has recently described an effect by norepinephrine on some phases of ureteral peristalsis.

In ureteral colic, certain enzyme products have been of value in helping stones pass through the ureter. Their effect has been in reducing periureteral edema, thus



**Fig. 5. Retrocaval Ureter:** Typical case showing medical deviation of right ureter at L3 with associated right hydronephrosis.

enlarging the ureteral lumen, but not affecting ureteral peristalsis, per se.

As noted previously, because of its close association with other intra-abdominal organs, radiation of or surgery on these organs may affect the ureter, with sequelae of ureteral damage and possible loss of renal function. A prime example is radiation for carcinoma of the cervix resulting in uretero-renal involvement. This may also occur in abdominal radiation for retroperito-

neal lymphomas, Hodgkin's disease, testicular tumors, etc.

### "Idiopathic Retroperitoneal Fibrosis"

In 1948, Ormond<sup>6</sup> described a new entity now commonly known as "Idiopathic Retroperitoneal Fibrosis."

This condition occurs mainly in middle-aged men, is usually bilateral, and may be associated with allergies to ergot preparations or sulfa drugs.

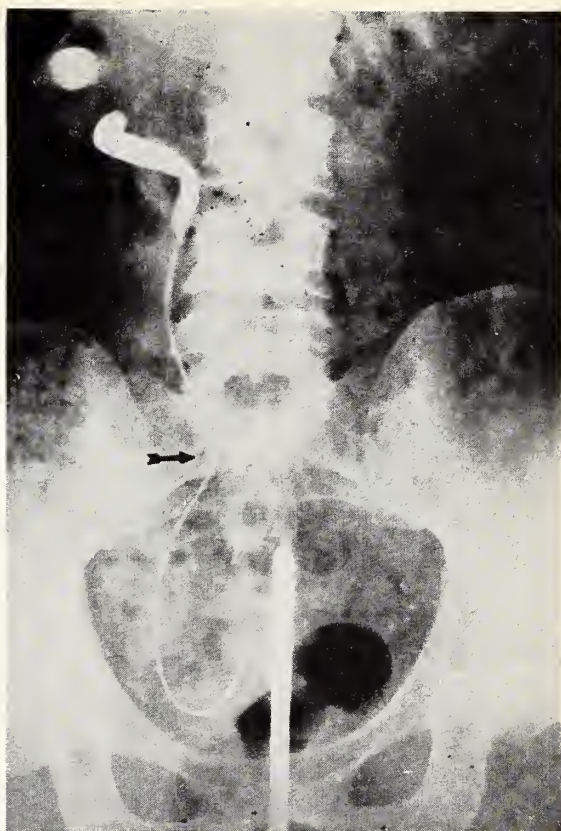
Pathologically, it is a non-specific retroperitoneal fibrosis which may encircle all



**Fig. 6. Megaureter:** Note enormous size of ureter as compared to relatively normal-sized kidney.

the surrounding tissues, and can involve the major vessels, colon, mediastinum, ureter, etc. Since most of these lesions can accommodate to gradual constriction, the disease may be present for some time before its true nature manifests itself, but constriction of the ureter results in uremia, and death may be the end result before the diagnosis is established.

The usual symptoms of this entity are related to the gastrointestinal tract, and may vary from simple pain and nausea to extreme vomiting, depending on the extent of uremia present, and intestinal involvement.



**Fig. 7. Idiopathic Retroperitoneal Fibrosis:** Case proved at surgery. Note classical deviation of ureter at L5-S1. This is usually a bilateral disease.

Retrograde pyelography reveals a medial deviation similar to that of the retrocaval ureter, but here the deviation is at L5-S1 (Fig. 7) and not L3.

Treatment is immediate surgery, with freeing of the ureter from surrounding obstruction. All ergot and sulfa drugs must be discontinued. The prognosis is favorable if the kidney is not at the point of no return.

Inflammations of the ureter, both specific and non-specific, do occur. They may be acute or chronic, and as previously noted, may mimic involvement of contiguous organs. They are usually secondary either to renal or peri-ureteral lesions, and can simulate acute appendicitis, ovarian disease or intestinal disease.

Specific inflammations respond to the specific therapy of the associated renal lesion. Viz—triple drug therapy for tuberculosis of the kidney will prevent further progression of ureteral tuberculosis. As will be noted, the resultant healed stricture may be as bad as the original disease in destroying renal function.



## Stricture

Stricture of the ureter may be congenital or acquired. Three strictures normally occur; namely, 1. at the ureteropelvic junction, 2. where the ureter crosses the iliac vessels, and 3. at the uretero-vesical junction.

Acquired strictures may result from inflammation, trauma, tumor, radiation effect, or bizarre lesions such as endometriosis and amyloid disease. Symptoms vary with the location of the stricture and the degree of renal obstruction.

With the influx of people from warmer climates, rarer ureteral lesions such as malacoplakia and schistosomiasis (Fig. 8) may occur. They can produce symptoms of hematuria and findings of ureteral infection and obstruction.

At this point, I should like to stress a lesion of the ureter frequently overlooked as a cause of urinary symptoms, namely, the "ureteral stump."

When a kidney is removed, very often a section of ureter attached to the bladder is left behind. This may undergo neoplastic changes, form calculi or continue as a source of infection. The fact that a kidney is removed does not absolve the remaining stump of ureter as an offending organ.

As was previously alluded to, involvement of the ureter by various conditions such as amyloidosis, Hodgkin's disease,

syphilis, polyarteritis nodosa, endometriosis, etc. must be considered when the major lesion is confirmed. With this in mind, subsequent renal involvement may be prevented or at best contained by treating the primary lesion.

The signs and symptoms of acute ureteral colic are well known. Pain varying from mild to extremely severe, localized or radiating to the lower abdominal quadrant, etc. may be present. Hematuria usually occurs and infection depends on the degree of renal obstruction.

In the differential diagnosis, many conditions must be eliminated, namely: acute intestinal obstruction, acute gall bladder colic, acute appendicitis, acute pancreatitis, acute coronary thrombosis, herpes zoster, mesenteric thrombosis, ruptured gastric ulcer, saddle thrombi, etc.

A proper history and physical, X-ray evaluation, cystoscopic studies and laboratory tests help establish a proper diagnosis.

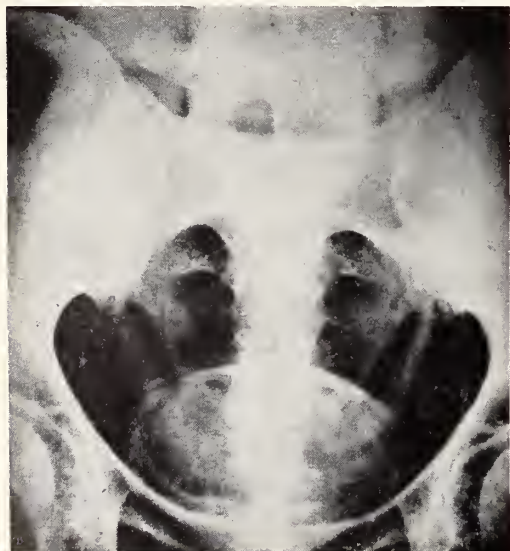
## Ureteral Tumors

Primary ureteral tumors do occur. They may be benign (very rare) and malignant (rare). (Fig. 9 A & B)

Unfortunately, most patients have had symptoms averaging about seven months before a proper diagnosis is made, and since most malignant ureteral tumors have a serious prognosis, it is incumbent on the first physician who sees the case to try and establish the diagnosis.

Apropos of this, the so-called normal intravenous pyelogram comes under serious condemnation. No intravenous pyelogram can be reported as normal unless the *entire* ureter is completely visualized. The so-called peristaltic space gap has been shown in our reports to harbor a malignant tumor even in the presence of a normal proximal ureter and kidney. We have postulated that in cases with hematuria, the entire ureter must be visualized either on intravenous pyelogram or retrograde pyelography before the report can be considered normal.<sup>7</sup>

The ureter in obstetrics and gynecology occupies a very special niche. Dilatations produced during pregnancy may result in hydronephrosis, pyelonephritis, and may possibly be related to toxemia of pregnancy. Whether these dilatations are hormonal or, as is the prevailing opinion,



**Fig. 8 Schistosomiasis of Bladder and Ureter:** Flat plate showing typical calcifications of wall of bladder and lower ureter.





**Fig. 9a.** Carcinoma of the Ureter: Retrograde pyelogram reveals normal kidney on both sides.



**Fig. 9b.** Ureterogram reveals defect in right mid-ureter with dilatation immediately above and immediately below malignant ureteral lesion.

mechanical in nature, is still debatable.

Because of the close anatomic relationship of the ureter to the ovaries, uterus and cervix, any lesion involving these organs could involve the former by contiguity.

The ureter has been used in an extra-urinary manner in the surgical treatment of hydrocephalus and ascites.

In the former, the distally cut ureter is anastomosed into the spinal canal and drains excessive spinal fluid, and in the latter, it is anastomosed to the peritoneal cavity. In both, the excessive fluid is drained out through the bladder.

It is in pediatrics that the ureter really presents itself as a major organ.

In this age group, one finds most of the anomalies and renal mayhem produced by incompetent ureters, namely: megaloureters (primary and secondary), and ascending urinary infections with renal damage due to involvement of the proper urine outflow.

Even such a simple condition as enuresis may involve a ureteral anomaly, with insertion into the vagina instead of the bladder. A proper urological workup is recommended in all cases of prolonged enuresis.

In recent years, no single urological subject, with the possible exceptions of renovascular hypertension and renal transplants, has so occupied the urological literature as has that of "ureteral reflux."

A whole new concept of renal infections, hypertension, chronic pyelonephritis, etc.,

have been traced to this condition. It is now fairly well accepted by all researchers in this field that the presence of reflux is never a normal phenomenon at any age. It may be present without symptoms, but usually is associated with recurrent pyuria, temperature, weakness, anemia, failure of proper growth, anorexia, and even mental retardation in the young.

A thorough urological workup including intravenous pyelogram, cystoscopy and voiding cystourethrograms, cine studies, etc., will often establish a working diagnosis, and should be performed as soon as possible.

Therapy varies from a conservative regime in mild cases to surgery in advanced or progressive cases. Proper treatment, before irreversible renal damage occurs, can lead to a favorable prognosis.

### Summary

A brief discussion of the importance of the ureter in health and disease is presented.

The kidney is a vital organ, and its existence and well being are intimately related to that of its associated ureter.

Primary diseases of the ureter are becoming more recognizable in the differential diagnosis of abdominal lesions.

The importance of ureteral involvement in obstetrics and gynecology is noted.

Undiagnosed abdominal lesions may be traced to the presence of an involved ureteral stump.

A complete ureterogram is necessary in the differential diagnosis of hematuria. Early neoplasms may thus be diagnosed.

Ureteral reflux is a major urological entity, and requires careful analysis and therapy.

In pediatrics, the ureter assumes the function of a major organ. Proper evaluation of ureteral involvement is necessary for the well being of a child.

Care must be taken in abdominal surgery to avoid any type of ureteral injury. ◀

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## Clinics for Crippled Children Scheduled

Twenty-four clinics for Illinois' physically handicapped children have been scheduled for January by the University of Illinois, Division of Services for Crippled Children. The Division will conduct twenty general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing service. There will be three special clinics for children with cardiac conditions and rheumatic fever, and one for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative service.

- Jan. 6—Rock Island General—Moline Public Hospital
- Jan. 7—Hinsdale—Hinsdale Sanitarium
- Jan. 8—Sterling—Community General Hospital
- Jan. 8—Flora—Clay County Hospital
- Jan. 8—Springfield General—St. John's Hospital
- Jan. 8—Cairo—Public Health Building
- Jan. 9—Chicago Heights Cardiac—St. James Hospital
- Jan. 13—Peoria General—Children's Hospital
- Jan. 13—East St. Louis—Christian Welfare Hospital
- Jan. 13—Quincy—St. Mary's Hospital

- Jan. 14—Champaign-Urbana — McKinley Hospital
- Jan. 14—Elgin—Sherman Hospital
- Jan. 14—Joliet—St. Joseph's Hospital
- Jan. 15—Rockford—Rockford Memorial Hospital
- Jan. 15—Decatur—Decatur Memorial Hospital
- Jan. 15—Elmhurst Cardiac—Memorial Hospital of DuPage County
- Jan. 15—Macomb—McDonough District Hospital
- Jan. 23—Chicago Heights Cardiac—St. James Hospital
- Jan. 27—Peoria General—Children's Hospital
- Jan. 27—East St. Louis—Christian Welfare Hospital
- Jan. 28—Centralia—St. Mary's Hospital
- Jan. 28—Evergreen Park—Little Company of Mary Hospital
- Jan. 28—Springfield Cerebral Palsy—Diocesan Center
- Jan. 28—Mt. Vernon—Good Samaritan Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.





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**reviews**

THE EVOLUTION OF MEDICARE . . . FROM IDEA TO LAW, Office of Research and Statistics, Research Report #29, U.S. Department of Health, Education and Welfare, Washington, D.C.

Recently, well-known medical leaders and others who watch the political scene have again warned the medical profession to brace itself for another onslaught against the private practice of medicine and for sizable enlargement and extension of the present medicare program.

The warning is given that the early 70's may well mark another key period in the relentless march toward a complete national health care system (socialized medicine).

THE EVOLUTION OF MEDICARE is recommended as basic reading for all those who are leaders or who aspire to participate in the fight against further government intervention and control over medicine, and for all those who may occupy a position of strategic decision making within the organization of medicine.

This 150 page soft-cover booklet by the U.S. Department of Health, Education and Welfare provides a chronology of significant events leading to enactment of Medicare on July 30, 1965—events beginning with the nationalization of medicine in Germany in 1883.

The author, Peter A. Corning, described as a professional journalist, is presently completing his requirements for a doctorate in political science at New York University.

Mr. Corning has separated the "evolution" in United States into four categories, beginning in 1912 and ending in 1965.

THE EVOLUTION OF MEDICARE is suggested as required reading because those who understand the past and the important strategic actions of the proponents of a huge governmental medical complex are those who can make proper and practical decisions for the future.

After having undergone a five year period of consolidation of the current Medicare program, government strategists who desire to completely destroy the private competitive enterprise system within which American medicine has done so well, are ready to strike again—that is if enough friendly votes are available in Congress after the 1970 election.

THE EVOLUTION OF MEDICARE is a story of the cooperation between the labor unions, social action agencies, the federal government, members of Congress, large church groups and others who favor socialized medicine. Organized labor is portrayed as the rallying point.

For those who do not support expansion of government health services and for those who believe that greater government involvement is a negative concept, THE EVOLUTION OF MEDICARE can be a valuable learning device in charting a positive course for the future.

Printed at government expense, the book is for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402—price \$.65.

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# *Surgical Aspects of* **Metastatic Bone Disease**

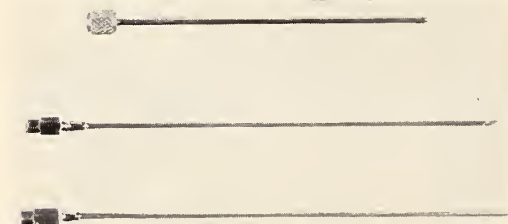
BY WILLIAM F. HEJNA, M.D. AND CLARENCE H. FOSSIER, M.D./CHICAGO

*Too often it is presumed that the occurrence of a carcinoma metastasis in bone heralds a futile situation so that the diagnostic and therapeutic approach becomes non-aggressive. In view of the difficulty predicting longevity and in the interest of the patient's comfort, activity level, psychological sense of well being, and hospital costs, it is urged that definitive diagnostic and treatment measures be carried out promptly. It is the intent of this paper to emphasize the valuable service which certain surgical procedures serve in this regard. Specifically, bone biopsy is a direct method of diagnosis and will be discussed briefly. Further, open reduction with internal fixation of pathologic fractures is considered to be an invaluable aspect in the overall management of patients with metastatic bone disease. A bold approach based on imaginative yet mechanically sound principles is advocated in these cases.*

## **Bone Biopsy**

Accordingly, open or closed bone biopsy should be considered early when diagnosis is sought or tissue diagnosis confirmation is desired prior to initiating therapy. These procedures are safe, inexpensive, and offer certain advantages over other diagnostic techniques. For example, blood studies such as serum Calcium and Alkaline Phosphatase may be in the abnormal range, but are not diagnostic. Standard X-rays of long bones serve to define the exact location and extent of a lesion as well as to demonstrate the presence of a pathologic fracture when it exists; however, 50% of the bone substance must be absent to evidence a radiolucent defect in a vertebral body. Clain<sup>1</sup> stated that in 1,360 vertebral metastases over 10% had normal X-rays. Bone scan is useful but non-specific in that it will show increased uptake in such areas as osteomyelitis and fracture. The latter is a particular deterrent in compression fractures where metastasis is suspected. Furthermore, the cost of bone scans is high. Specialized X-ray techniques such as laminography and myelography serve a useful diagnostic purpose in certain instances, however, they do not provide the valuable information which tissue diagnosis does. Further discussion of these techniques does not serve the purpose of this paper.

Bone biopsy techniques include needle aspiration, open trephine biopsy, and closed trephine biopsy. The first of these is akin to marrow aspiration and is acceptable when the lesion is accessible and soft enough to aspirate into a large bore needle. Trephine biopsy is considered preferable



**Fig. 1** Instruments for vertebral body biopsy: (top) outer protective sleeve, (middle) spinal needle, (bottom) 3/32 inch trephine.

since it can be performed under local anesthesia in most areas and specimens up to three-eighths inch in diameter can be taken with relatively little dissection. In areas buried under heavy musculature general anesthesia is preferred, but not necessary. Of particular note is the vertebral body biopsy which is carried out under fluoroscopy with a 3/32 inch trephine. Fig. 1 demonstrates the required instruments and Fig. 2 (Case 1) shows the trephine in place. A one-fourth inch stab wound is made one hand's breadth lateral the posterior spinous process, and the sleeve with the spinal needle is inserted at a 45 degree angle to the skin. The patient lies prone and the left side is preferred to avoid possible injury to the vena cava. Local anesthesia is injected as the instrument is advanced to the surface of the vertebral body. The needle is then removed leaving the sleeve in place and the trephine introduced. Position is confirmed by fluoroscopy or X-ray and the specimen taken. Thoracic vertebral bodies are more difficult to biopsy in that the ribs obstruct a straight forward approach. Bone sections can be ready for interpretation within 20 hours providing accurate data upon which to base treatment.

In the patient with painful bony metastasis, it would seem reasonable to utilize whatever non-surgical measures might be available to provide comfortable mobility and prophylaxis against fracture complications. The range of conservative treatment applied to such localized painful metastasis is broad and the most important of these is radiation therapy. Two thou-



**Fig. 2** Case 1. X-ray at the time of vertebral biopsy.

sand to three thousand r. is usually given over a two week period of time. This treatment is aimed at providing symptomatic relief and aiding in fracture healing. Other techniques used include splintage, trunk corseting or bracing, gait support in the form of a cane or crutch, analgesia, modified activity level, and rarely ablative surgery.

### Prophylactic Fixation

An additional surgical procedure felt to be of great value in minimizing morbidity related to pathologic fractures is prophylactic fixation of metastatic lytic lesions when these are accessible; particularly, when such areas are susceptible to stress, e.g., neck of femur. It is felt that this procedure is advantageous for the following reasons: 1) the procedure is done electively rather than as an emergency allowing adequate preparation of the patient, 2) the patient is spared the traumatic event of a fracture, 3) delay of fixation occasionally allows a local pathologic situation to develop which then cannot be fixed, 4) a prophylactic intramedullary fixation procedure can frequently be done without actually exposing the lesion site. Case 2 illustrates the value of prophylactic fixation.

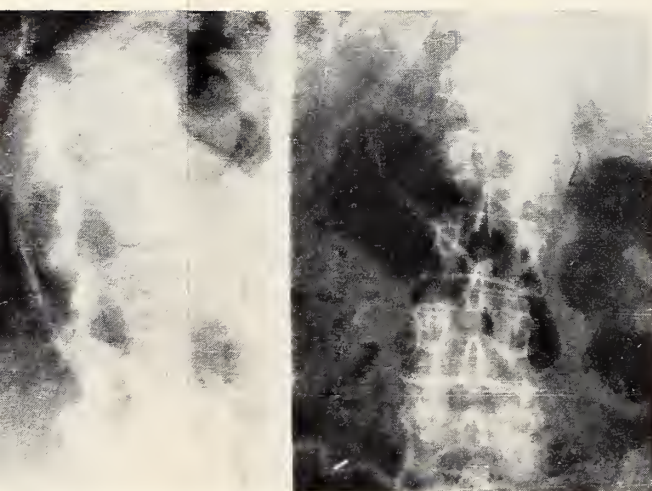
The patient who sustains a fracture through a metastasis in a long bone very often is not adequately helped by conservative measures alone and is truly incapacitated. Such fractures differ from traumatic fractures in normal bone in several ways making conservative treatment more difficult. For example, the bone substance loss due to tumor invasion often renders the fracture markedly unstable and thus unsuitable for simple cast immobilization. If traction is used as the primary treat-



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**Fig. 3** Compression fracture of L2 in a patient with a history of "cancer of the womb." Biopsy (Fig. 2) revealed metastatic squamous cell carcinoma.



**Fig. 4b** With internal fixation, the patient remained ambulatory until time of death, 10 months later.



**Fig. 4a** Case 2. Lytic lesion present in the neck of the left femur.



**Fig. 5a** Case 3. Pathologic fracture through lytic lesion of left femur.



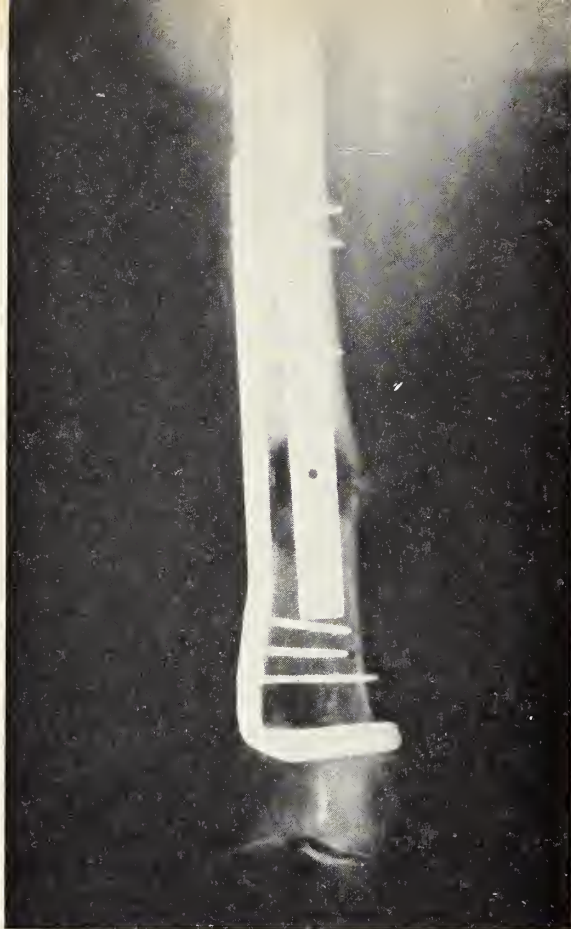
ment, the hospitalization is prolonged limiting severely the number of days remaining available to the patient in his home or with his family. In addition, patients who are aware that tumor is responsible for such prolonged hospitalization and its attendant costs frequently develop severe psychological depression. When feasible, open reduction and internal fixation or prosthetic replacement should be carried out in these instances and radiation therapy should be given.<sup>2,3,4</sup> Several case demonstrations follow to illustrate various bone sites and types of lesions which can be treated as well as devices available for such fixation.

### Case Reports

**Case 1** D. L., 53-year-old white female, fell sustaining a compression fracture of L2. (Fig. 3) Three years previously she had had a hysterectomy at another institution for "cancer of the womb." Histologic confirmation was not available. Vertebral biopsy revealed metastatic squamous cell carcinoma. Subsequently, appropriate radiation therapy was delivered to the vertebral body with symptomatic improvement in the patient's pain.

**Case 2** M. S., 79-year-old white male, with bronchogenic carcinoma metastatic to the neck of the left femur. The large lytic lesion (Fig. 4a) was noted when an X-ray was taken for hip pain and a prophylactic fixation with nail and plate was carried out. (Fig. 4b) The procedure was performed without difficulty and as much as there was no displacement, no reduction was necessary. The total hospitalization was 10 days and the patient remained ambulatory with crutches and partial weight bearing to the time of his death, 10 months later.

**Case 3** K. K., 60-year-old white female with carcinoma of the breast metastatic to the left femur. On changing position in bed, she sustained a fracture through the lytic lesion which was present (Fig. 5a) and had marked pain and deformity. The fracture was markedly unstable and was treated with right angle blade fixation. Intramedullary rod fixation is unsuitable in this instance because of the size and location of the lesion and the wide medullary canal in this portion of



**Fig. 5b** Fixation of fracture with right angle blade plate. Intramedullary fixation is unsuitable at this level because of the width of the medullary canal.

the bone. The lesion failed to fill in by the time of the patient's death one year later, however her hospitalization at the time of the fracture was 10 days and she was ambulatory for the greater portion of the remainder of her life.

**Case 4** I. G., 63-year-old white male, who had malignancy of the kidney metastatic to the upper end of the right femur. Fig. 6a shows a fracture of the neck of the femur through the lytic lesion, the extent which can be seen to extend well down on the calcar femorale to the level of the lesser trochanter. A long stem head and neck prosthesis was utilized so that this invaded area could be largely excised and the weight bearing portion of the prosthesis would be on more normal bone. (Fig. 6b) The patient was discharged from the hospital ambulatory and full weight bearing 11 days following the surgical procedure. He continues to be ambulatory with only mild discomfort in the hip region at the time of this writing 19 months after surgery.



**Fig. 6a** Case 4. Pathologic fracture with tumor involvement of calcar femorale.

**Case 5** B. B., a 37-year-old male with multiple myeloma developed a lytic lesion and subsequently a fracture through this lesion. (Fig. 7a) Treatment consisted of intramedullary fixation, chemotherapy and local radiation (Fig. 7b). The hospitalization time was seven days with a total of three weeks lost from his job. This is of some importance in the young patient with family responsibilities. At the time of rod removal one year after the fracture, rebiopsy of the original lesion site revealed no myeloma cells.

### Discussion

In most instances, the site of origin is known at the time the metastasis is discovered and it remains simply to verify this point. The most common of these are well known and include carcinoma of the breast, prostate, kidney, thyroid gland and lung. Of 2,000 patients with secondary malignant disease of bone studied by Clain, 50% originated from the breast; however, prostatic carcinoma shows a higher predilection for metastasis to bone. Not to be forgotten are those tumors arising in the stomach, colon, uterine cervix, adrenal gland, and larynx, which may metastasize to bone. Of all metastases to long bones,

25% will result in fracture, and the incidence of non-union is 95% when internal fixation is not used.

Radiation treatment is effective in the treatment of lytic lesions, causing them to fill in when a stabilizing device is present. Interestingly it abets non-union when fixation is not used.<sup>5-6</sup> Thus both tumor and radiation retard callus formation, but it is generally thought that irradiation of a fixed pathologic fracture causes shrinkage of the tumor removing the mechanical block to normal fracture healing mechanisms. Another frequent question involves the effect of the metal implant on the tumorcidal dose of radiation in bone. The shielding by the implant amounts to roughly 30% of the radiation dose; however, this factor is negated by the use of multiple ports. There are one or more conditions which make open reduction and internal fixation impossible. Pathologic fracture of the axial skeleton is obviously not amenable to internal fixation and one must rely on radiation therapy and external sup-



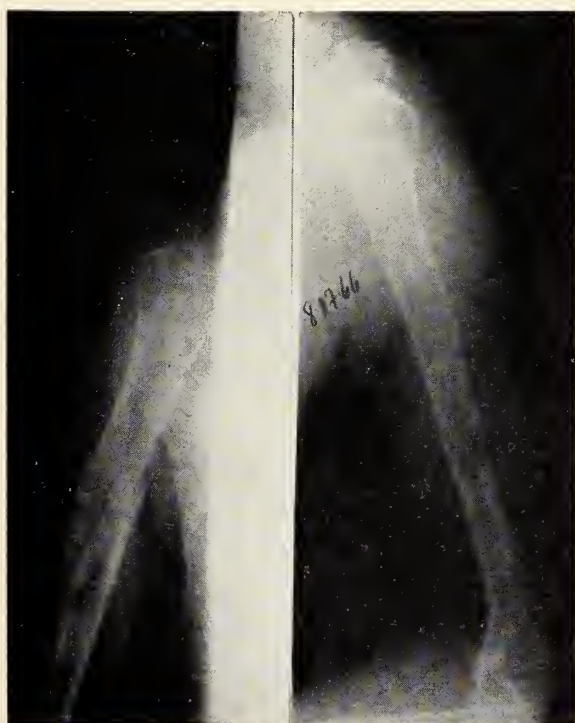
**Fig. 6b** Long stem head and neck prosthetic replacement. Patient alive and doing well, 19 months later.



port for symptomatic relief. Metaphyseal lesions adjacent to the elbow, wrist, knee, or ankle joints are technically impossible to stabilize by the use of an internal device since purchase cannot be gained on both sides of the lesion and successful prosthetic replacements for these areas have not been devised. A third group includes those patients whose life expectancy is less than six months or whose general status is such that they would not tolerate an anesthetic or surgical insult. Fourthly, in pathologic fractures in the hands or feet, there is frequently not adequate bone stock present to carry out open reduction.

### Conclusion

While metastatic disease to bone at this time signifies a failure of "cure" in a cancer patient, there are multiple procedures available to alleviate pain and allow the patient to lead a more normal life. Thus prophylactic fixation and internal fixation of pathologic fractures combined with radiation therapy is strongly urged. The value of biopsy for definitive diagnosis especially in vertebral metastasis is obvious and can be done with little morbidity. ◀



**Fig. 7a Case 5. (Right) Multiple myeloma metastatic to left humerus, (left) subsequent fracture through involved area.**



**Fig. 7b Fixation with a Rush rod followed by chemotherapy and local radiation. Biopsy one year later revealed no myeloma cells present.**

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### Public Affairs and Legislation

In acting upon the report of the Council on Legislation and Public Affairs the Board authorized further study of HB 1479. This bill, still alive in the Illinois General Assembly, would expand coverage and eligibility under Medicaid and provide administration of the program by an insurance carrier. Monitoring of action of the Constitutional Convention, in the usual legislative manner, was authorized. Con-Con convenes Dec. 8. Approval was given to request the AMA Delegation to introduce a resolution at the Denver meeting directing the AMA to establish a Public Affairs Information Exchange Service. ISMS will participate in the National Public Affairs Meeting in Washington, D.C., convening under the auspices of the new AMA Public Affairs Division, Feb. 27-Mar. 1, rather than holding its own customary Roundup in conjunction with the annual Public Affairs meeting of the U.S. Chamber of Commerce. In related action, the Board authorized the council to study the question of the abolishment of the Coroner System in favor of the Medical Examiner System. Active consideration of this matter is anticipated in the Constitutional Convention, since the office of the coroner is required in the present constitution.

### Jaycees and ISMS to Cooperate on Physician Shortage Problem

A recommendation of the Task Force on Physician Shortage and Services to Medically Deprived Areas, to utilize the assistance of the Illinois Jaycees in the campaign to alleviate shortages, was approved. The initial step will involve a survey of needs via the 290 Jaycee chapters in the state. County Medical Societies will be asked to cooperate. The aim of the Task Force is to initiate programs to alleviate the physician shortage, retain physicians produced in Illinois, and improve the delivery of health care in medically deprived areas.

The AMA Delegation also announced plans to introduce a resolution at Denver calling upon the AMA Board of Trustees to study the total picture of training for medical students, interns and resident physicians, and to exercise influence toward a wider distribution of this training to non-medical school affiliated hospitals, as an aid to future practice in rural and suburban communities.

### Clarification of Position on Fees

In responding to a request from a county medical society on the application of coefficients to a relative value scale, the Committee on Usual and Customary Fees proposed and the Board adopted the following statement:

"There is no current fee schedule or Relative Value Scale being formally utilized by the physicians of Illinois. It is recommended that a County Medical Society embrace the full range of fees as delineated by the Usual and Customary Fee definition of all physicians in the area."

In further responding on the right of a physician to charge patients that portion of his fee not covered by an insurance plan, the Board adopted the following:

"A physician/patient relationship is such that the contractual agreement for reimbursement is between themselves. There is no contractual relationship present with any third party and therefore the patient is responsible to the physician for payment of his fees."

## Changes in Student Loan Program

Upon recommendation of the Council on Education and Manpower, the Board approved use of interest funds in the ISMS-IAA Student Loan Fund program to produce promotional literature to acquaint medical schools and students with the Fund. An increase in loans from a maximum of \$1,250 to \$1,500 was approved and the 5-year practice agreement was amended to provide for one year of practice for each year of loan. These actions are subject to ratification by the ISMS-IAA Student Loan Fund Board.

## SIU Clinical Center at Springfield

Dr. Trumpe reported on the anticipated Springfield clinical center of the new SIU medical school. Some capital funds are still needed. The proposed opening was to be within two years and the initial enrollment would be between 25 and 75.

In other actions the Board:

- Approved categories for Journal advertisements as such pertain to alcoholic beverages;
- Approved the recommendation of the Publications Committee that the Journal continue to be printed by the Neely Co.;
- Heard a report by the Executive Committee regarding Headquarters office space needs and approved negotiations for additional space;
- Was in accord with the position statement "Let's Talk Sense About Sex Education" developed by members of several agencies and in accord with Resolution 69M-23 and various AMA resolutions;
- Endorsed a position statement on Air and Water Pollution delivered by President-Elect J. Ernest Breed to the Metropolitan Sanitary District;
- Referred to the Finance Committee a request for funds to continue the SAMA summer job-education project;
- Approved travel expenses of four students on the ISMS SAMA Advisory Committee to attend the AMA Denver Convention;
- Referred to the Executive Committee for action the list of names of medical students (SAMA) suggested for appointment to ISMS committees, per House of Delegates action;
- Authorize a contribution of \$100 to the Illinois Interagency Committee on Smoking and Disease and that the Child Health Committee appoint an official representative;
- Authorized the Council on Mental Health and Addiction to send designate members of the Council as a delegate and an alternate to meetings of the Mental Health Planning Board's Council of Professional Societies;

## Appointments

- Dr. William Walton, Belleville, to the Constitution and By-laws Committee;
- Dr. William E. Adams, Chicago, to represent ISMS at the U.S. Pharmacopeal Convention, April 8-10;
- Dr. Donal Stehr, Havana, to the Task Force on Physician Shortage and Services to Medically Deprived Areas;
- Liaison committee to explore mutual areas of concern with Illinois Podiatry Society: Dr. Joseph R. O'Donnell, Chairman, Drs. Williard Scrivner, Warren Young and Maurice Hoeltgen;



- Dr. Eugene Diamond, Chicago, to represent ISMS at the White House Conference on Nutrition and Health, Nov. 30-Dec. 4;
- Drs. Philip C. Lynch, Decatur, and Fred Z. White, Peoria, to represent ISMS at AMA Council on Medical Service (Peer Review), Oct. 5, Chicago;
- Dr. John Troxel, Chicago, to represent ISMS at the Highway Safety Conference, Ann Arbor, (also attending as a representative of Blue Shield).

#### Nominations for appointment to state committees—

##### Subcommittees of the Hospital Licensing Board:

Nursing Standards—Drs. W. I. Taylor, Canton, Paul Theobald, Bloomington

Rehabilitation Standards—Drs. Joseph Koczur, Chicago, Arthur Rodriguez, Chicago, Kate Kohn, Chicago, Aaron M. Rosenthal, Chicago, Rex McMorris, Peoria

Pharmacy Standards—Dr. Robert C. Muehrcke, Oak Park  
Advisory committee to the Secretary of State, to establish eye examination standards: Drs. Frank J. Kresca, Champaign, Burton Krimmer, Chicago, Edward Kwedar, Springfield, Wallace F. Strow, Springfield, Clifford Sullivan, Chicago

Department of Public Health Tuberculosis Advisory Committee  
T. B. Sanitarium or Care and Treatment Center Board—Drs. E. Lee Strohl, Chicago, Frank J. Jirka, Jr., River Forest

Voluntary T. B. Organization—Messrs. John Egdorff, Chicago, Ben Kinningham, Chicago

Physician Administrator of T.B. Hospital or Clinic—Drs. E. A. Piszczek, Chicago, Darrell H. Trumpe, Springfield, M. R. Lichtenstein, Chicago, Dan Morse, Peoria

Registered T.B. Nurse—Barbara Riblon, R.N., Chicago  
Physician Administrator—Local Public Health Department—Drs. Otto Bettag, Glen Ellyn, John B. Hall, Chicago

## Obituaries

\***Milton E. Bitter**, Quincy, died September 29 at the age of 70. He was past president of the Adams County Medical Society.

\***Glenn A. Burckart, Sr.**, Chicago, died October 4 at the age of 61. He was senior medical staff member at Christ Community and Evangelical hospitals.

\***Ernest C. Burhans**, Peoria, died October 3 at the age of 70.

\***Anthony F. Delfosse**, Chicago, died October 6 at the age of 79. He was a member of the ISMS Fifty-Year Club.

**Ernest A. Johnston**, Chicago, died July 25 at the age of 86.

**Stephan Krywokulsky**, Chicago, died

April 1 at the age of 70. He received his medical degree in Poland.

\***Dwight A. Pence**, Decatur, died September 23 at the age of 64. He was past secretary of the Macon County Medical Society.

\***Hiram E. Ross**, Danville, died June 21 at the age of 80. He was past president of the Vermilion County Medical Society and a member of the ISMS Fifty-Year Club.

\***Bertha P. Schmulevitz**, Chicago, died July 16 at the age of 78. She was a member of the ISMS Fifty-Year Club.

\***Robert G. Smith**, Waukegan, died July 11 at the age of 77.

\*Indicates member of Illinois State Medical Society.

Due to the many new bills passed and subsequently signed into law by the governor, and such action occurring principally after the publication deadline for the October "Reference Issue" of the **Illinois Medical Journal**, the Medical Legal Information section of the "Reference Issue" is presented here. The reader is urged to maintain this issue along with the "Reference Issue" or to remove the pages from this issue and tip them into the October issue.

## Medical Legal Information

(Prepared by ISMS Legal Counsel, Frank M. Pfeifer)

### LEGAL SERVICES OF ISMS

The Illinois State Medical Society retains a General counsel and occasionally uses the services of special counsel in implementing its various programs. Legal advice is given to the state society and its components as organizations, but is not available to individual members.

It is intended that this article give general information only; for any specific problem consultation should be had with the physician's individual attorney.

### HOW TO SET YOUR AFFAIRS IN ORDER

A physician's death, expected or not, often creates burdensome tasks for survivors. Natural grief is complicated by the necessity for rapid decisions and hurried searches for required information. Significant papers may be so well put away that prolonged seeking in various places may be required, with added pain for the bereaved.

It is therefore suggested that the physician, during his lifetime, ease the situation by compiling in one place needed information about the location of important records and papers. In addition, the Illinois State Medical Society urges each member to have a will prepared by a competent attorney and to have the said will re-evaluated by an attorney whenever there is a material change in any of his circumstances or in the law of his state.

The executor named in the will can handle the doctor's estate most efficiently if he has access to specific information.

The physician should, of course, leave information about insurance, real estate, and bank accounts just as everyone else does, but he has additional responsibilities peculiar to his profession. He should leave instructions for:

The legal department of the Society can answer specific questions propounded by officers of county medical societies in Illinois, which are part of and make up the state society, if the questions are of interest to the membership as a whole.

Although the Society and its counsel cannot provide personal advice to ISMS members, it is to every physician's advantage to acquaint himself with as much general medical-legal knowledge as possible. The following section, therefore, is devoted to this kind of information.

1. Temporary coverage of his practice. Some arrangement with a colleague should be made immediately for hospitalized patients, and others should be notified of the doctor's death.

2. Patient records, which should be carefully preserved for a minimum of 10 years and for 25 years, if possible. Contents of the records should be turned over to another physician upon written request.

3. Return of unused narcotics to the Treasury Department, the narcotics tax stamp and order book to the Internal Revenue Service, and retention of the narcotics ledger for two years.

4. Disposal of his practice. If it is to be sold, rapid action is advised as value is lost quickly. Equipment is best disposed of with the sale of the practice.

5. Benefits that may be due survivors from unused insurance premiums, Blue Cross-Blue Shield, Veterans Administration, or Social Security.

As soon as practical after death, the attorney who will handle the estate should be contacted and his advice followed thereafter.

### LEGAL LIABILITY OF PHYSICIANS

The legal liability of physicians is a question on which much has been written. It has also been the topic of discussion at many meetings of medical and medical-legal groups. However, because of the grave nature of the problem, the Illinois State Medical Society's legal counsel believes that the subject cannot be overemphasized.

Statistics prove that the number of malpractice and general liability suits against physicians is on the increase. This does not mean that physicians are becoming less skillful or more careless in their diagnosis and treatment; it probably means that physicians are being affected by the tremendous

growth there has been recently in all types of personal injury litigation.

More people than ever before are receiving medical attention and more are starting lawsuits against physicians when recovery is less than complete.

#### Liability Insurance

For this reason, it is essential that every physician carry liability insurance to protect him against all possible claims. The physician should be aware, however, that there are some inadequate policies on the market today and an



attorney should be consulted before contracting for insurance that may not cover the doctor's particular circumstance. Additional coverage insofar as limits are concerned is relatively inexpensive and should be carried in sufficient amount to cover all possibilities.

Prior to the 1967 Session of the General Assembly of Illinois, the greatest recovery that could be had for wrongful death was \$30,000 but this limitation has now been removed and there is no limit in the amount which may be recovered in the case of wrongful death. This means that in malpractice cases resulting in death, the verdict could be extremely high. It is therefore recommended that all physicians take a look at their malpractice insurance policies to determine that they are properly covered and in adequate limits. The cost of this insurance does not materially increase with the increase in limits and therefore extremely high limits are suggested.

A physician today is a "sitting duck" for a lawsuit even though he may in no way be guilty of negligence. And lawsuits to defend, no matter how meritorious, require the expenditure of time and money.

Legal implications in this field are wide, but basically the physician is liable for his own negligent acts and the negligent acts of all his employees. In the case of a partnership, he is also liable for the negligent acts of his partners.

While the right kind of insurance in sufficient amount will protect the physician financially, steps should be taken by all doctors to help minimize the filing of lawsuits of this kind and to work for reduction in the number of guilty verdicts being obtained.

The American Medical Association has prepared, and has available for distribution, several interesting pamphlets and papers on this subject. The pamphlet entitled, "Professional Liability and the Physician," reprinted from the February, 1963 issue of the *Journal of the American Medical Association*, contains this statement:

### Physician's Responsibility

"In the final analysis, the physician himself must share the responsibility for the continuing existence of the unpleasant professional liability situation. Many physicians have been satisfied to pay their professional liability insurance premiums and thereafter to sit back complacently, doing nothing until they become a target. Every physician must be brought to realize that this money payment is only part of his insurance program; a much more important part is his contribution of time, study, and attention to put into effect all possible measures to safeguard the patient, himself, and his colleagues. Professional liability is in no sense merely an insurance problem. It is a medical problem and must be combatted by members of the medical profession."

The AMA pamphlet goes on to say that "prevention is the best possible defense against claims and suits" and lists these 20 prevention "commandments":

1. The physician must care for every patient with scrupulous attention given to the requirements of good medical practice.

2. The physician must know and exercise his legal duty to the patient.

3. The physician must avoid destructive and unethical criticism of the work of other physicians.

4. The physician must keep records which clearly show what was done and when it was done, which clearly indicate that nothing was neglected, and which demonstrate that the care given met fully the standards demanded by the law. If any patient discontinues treatment before he should, or fails to follow instructions, the records should show it; a good method is to preserve a carbon copy of the physician's letter advising the patient against the unwise course.

5. The physician must avoid making any statement which constitutes, or might be construed as constituting an admission of fault on his part. He should instruct employees to make no such statements.

6. The physician must exercise tact as well as professional ability in handling his patients, and should insist on a professional consultation if the patient is not doing well, if the patient is unhappy and complaining, or if the family's attitude indicates dissatisfaction.

7. The physician must refrain from over-optimistic prognoses.

8. The physician must advise his patients of any intended absences from practice and recommend, or make available, a qualified substitute. The patient must not be abandoned.

9. The physician must unfailingly secure an "informed" consent (preferably in writing) for medical and surgical procedures and for autopsy.

10. The physician must carefully select and supervise assistants and employees and take great care in delegating duties to them.

11. The physician should limit his practice to those fields which are well within his qualifications.

12. The physician must frequently check the condition of his equipment and make use of every available safety installation.

13. The physician should make every effort to reach an understanding with his patient in the matter of fees, preferably in advance of treatment.

14. The physician must realize that it is dangerous to diagnose or prescribe by telephone.

15. The physician should not sterilize a patient solely for the patient's convenience except after a reasonably complete explanation of the procedure and its risks and possible complications and after obtaining a signed consent from the patient and from the patient's spouse if the patient is married.

Such sterilization is a crime in Connecticut, Kansas, and Utah and should not be performed in those states. Eugenic sterilization should be performed only in conformity with the law of the state, if any. Sterilization for therapeutic purposes may lawfully be performed with the informed consent of the patient and preferably with the informed consent of the patient's spouse, if the patient is married.

16. Except in an actual emergency situation which makes it impossible to avoid doing so, a male physician should not examine a female patient unless an assistant or nurse, or a member of the patient's family is present.

17. The physician should exhaust all reasonable methods of securing diagnosis before embarking upon a therapeutic course.

18. The physician should use conservative and less dangerous methods of diagnosis and treatment wherever possible, in preference to highly toxic agents or dangerous surgical procedures.

19. The physician should read the manufacturer's brochure accompanying a toxic agent to be used for diagnostic or therapeutic purposes, and, in addition, should ascertain the customary dosage or usage in his area.

20. The physician should be aware of all the known toxic reactions to any drug he uses, together with the proper methods for treating such reactions.

The general counsel for the Illinois State Medical Society has given the following suggestions on how to avoid and defeat malpractice suits:

1. Physicians should conduct their practice in hospitals so that they comply with and live up to the standards for hospital accreditation of the American Hospital Association, the hospital regulations adopted by the State Department of Public Health under the Hospital Licensing Act and the by-laws of the hospital in which they are practicing.

2. Physicians should keep up on modern medicine in the fields in which they practice so they are conversant with and use the latest proven developments.

3. Physicians should call in specialists whenever the need arises.

4. Physicians should provide for automatic consultation in all serious cases—it cannot be disputed that any physician being called on to defend his treatment in court is in a much better position if he can also bring forth as a witness the physician who reviewed the case and consulted with him, or the specialist in a given field called in by him.

5. Hospital records and those of the physician should be kept in such manner and in such detail as will be meaningful and show that adequate medical procedures were followed. It should be remembered that frequently cases are not filed until some time after the alleged injury took place and sometimes do not come to trial for several years thereafter.

6. All cases should be treated in such a manner and records kept as if the case would result in a malpractice suit and would not come to trial for a considerable period of time after the alleged injury had taken place.

7. Physicians should carry adequate malpractice insurance.

## Physician and Hospital Liens

Paragraph 101.1 of Chapter 82, Illinois Revised Statutes 1967, provides that every licensed physician practicing in the State of Illinois who renders service to an injured person, except services rendered under the provisions of the Workmen's Compensation Act and Workmen's Occupational Diseases Act, shall have a lien upon all claims and causes of action for the amount of his reasonable charges up to one-third of the sum recovered by the injured person. In order to effectuate this lien, notice in writing must be given to the injured person and also to the person or persons against whom such claim or right of action exists.

Under paragraph 97 of Chapter 82, Illinois Revised Statutes 1967, not-for-profit hospitals and those hospitals maintained by a county shall have a lien on all claims or causes of action for the amount of reasonable charges at ward rates up to one-third of the amount recovered. Again, in order to perfect the lien, it must be filed in the same manner as the physician's lien described above.

While the language is substantially the same under both liens, they are entirely separate enactments, neither is subservient to the other and, therefore, both the hospitals and the physicians can recover up to one-third of the amount received by the patient.

A suggested form of physician's lien notice is as follows:

### NOTICE OF LIEN

In favor of John M. Jones, M.D.

1424 Chestnut Street

Springfield, Illinois

Dated this ..... day  
of ....., 19.....

TO: .....  
.....  
.....

I am advised that .....,  
whose address is, .....,  
has a claim, right, or cause of action against you  
for injuries received, resulting from an accident on  
or about .....

You are notified that I claim a lien upon such  
claim, right, or cause of action for reasonable  
charges for medical services rendered said  
..... on account  
of said injuries, the total amount of such lien not  
to exceed one-third ( $\frac{1}{3}$ ) of any sums due or paid  
to such injured person by compromise, settlement,  
or satisfaction after the satisfaction of any attorney's  
lien, if any.



This lien is claimed pursuant to an Act providing for a lien for physicians rendering treatment to injured persons approved July 23, 1959 (Chap. 82, Sec. 101.1 through 101.6, Ill. Rev. Stats., 1967).

Money paid in settlement of this claim or in settlement or payment of any judgment or decree on this claim is subject to this lien, and before making settlement, you should consult with me and see that this lien is satisfied.

Signature

(This notice to be served on both the injured person and the parties against whom such claim or right of action exists, by certified mail or in person.)

Suggested form of authorization to be used by lawyer:

(Place) (Date)

"I, \_\_\_\_\_, hereby authorize and direct \_\_\_\_\_, my attorney, or attorneys to pay from the proceeds of any recovery in my case to Dr. \_\_\_\_\_ the reasonable amount for professional services in the treatment of injuries sustained by me and/or my wife and/or child or children, as the case may be, in an accident which occurred on \_\_\_\_\_, 19\_\_\_\_, said payment to include professional services heretofore rendered and those rendered to the time of the settlement or other disposition of my case for the treatment of said injuries, and fees for testifying in court."

"I further authorize said Doctor to furnish said Attorney with any reports he may request in reference to my injury. I understand that this in no way relieves me of my personal responsibility to pay all such medical charges."

Witness \_\_\_\_\_  
Signed \_\_\_\_\_

**Admissibility in Evidence of Deliberations of Tissue Committees**

In 1961 the Illinois legislature passed an act in which one of the purposes was to prevent the admissibility in evidence and making public the deliberations and findings of tissue committees. The act is set out at paragraphs 101-105 of Chapter 51, Illinois Revised Statutes 1967, and is as follows:

"101. All information, interviews, reports, statements, memoranda or other data of the Illinois Department of Public Health, Illinois State Medical Society, allied medical societies, or in-hospital staff committees or accredited hospitals, but not the original medical records pertaining to the patient, used in the course of medical study for the purpose of reducing morbidity or mortality shall be strictly confidential and shall be used only for medical research.

102. Such information, records, reports, statements, notes, memoranda, or other data, shall not be admissible as evidence in any action of any

kind in any court or before any tribunal, board, agency or person.

103. The furnishings of such information in the course of a research project to the Illinois Department of Public Health, Illinois State Medical Society, allied medical societies, or to in-hospital staff committees or their authorized representatives, shall not subject any person, hospital, sanitarium, nursing or rest home or any such agency to any action for damages or other relief.

104. No patient, patient's relatives, or patient's friends named in any medical study, shall be interviewed for the purpose of such study, unless consent of the attending physician and surgeon is first obtained.

105. The disclosure of any information, records, reports, statements, notes, memoranda or other data obtained in any such medical study except that necessary for the purpose of the specific study is unlawful, and any person convicted of violating any of the provisions of this Act is guilty of a misdemeanor."

While there have been no decisions under the act quoted by any of the Illinois appellate courts or the Supreme Court, it would appear that a tissue committee would come within the meaning of "inhospital staff committees of accredited hospitals," and, therefore, would be inadmissible in evidence and considered private and confidential. Unfortunately, the act does not define accredited hospitals, but this would probably mean either licensed hospitals or those accredited by the medical professions. (There are only 10 licensed hospitals in Illinois which have not been accredited by the medical professions.)

In addition to the above statute, the fact that tissue committees are not required by Illinois law, but are established through the voluntary co-operation of the hospitals and the medical profession for the betterment of medicine through research of prior cases, would be a powerful argument against admissibility.

Another legal argument against the introduction in evidence of such records would be the fact that the results would be the deliberations of a committee and there would be no way to cross-examine a committee, which would mean that a fundamental right was being lost by one or more of the litigants in the case.

As stated above, there are no decisions in Illinois which can be relied upon, but it is the opinion of the ISMS general counsel that such records cannot legally be used in any legal action.

It should be pointed out that in most instances subpoenas and subpoenas duces tecum (produce the records) are issued by the clerk of the court on application of one of the parties litigant and no determination is made as to the admissibility of the testimony or records until the witnesses and records are produced in court. It is suggested that if a subpoena or court order is ever received involving the records and deliberations of the tissue committee, your at-

torney be contacted immediately in order to file appropriate motions to suppress the production of the records. If the trial court should hold that such records are admissible, it is then suggested that an appeal be made to the Supreme Court of Illinois on this question, for if such records are produced, it could conceivably have the result of diminishing the efficiency or the ultimate abandonment of such committees, with the result that research and advancement in the art of medicine would be retarded.

### **Consent by Minors to Medical Treatment and Operations**

The general law in Illinois is that a minor cannot give legal consent or waive any rights which he has under the law. In the year 1961, the Illinois legislature made an exception to this rule by specifically providing that consent to the performance of medical or surgical treatment by a licensed physician could be executed by a married person who is a minor or a pregnant woman who is a minor and shall not be voidable because of such minority. This act further provides that any parent who is a minor may consent to the performance upon his or her child of medical or surgical procedures by a licensed physician and that the consent shall not be voidable because of such minority.

In the year 1969, the Illinois legislature made further exception to this rule by providing that:

1. Anyone 18 years of age or older may give binding legal consent to all medical and surgical procedures. (Consent for all operations or any unusual, improper or dangerous medical procedures should be in writing regardless of age.)

2. It is no longer necessary for either hospital or physician to obtain consent from parent or guardian before rendering emergency treatment to a minor, if the obtaining of the consent might adversely affect the condition of the minor's health.

3. Anyone over the age of 18 years may donate blood without the consent of parent or guardian.

4. Any minor 12 years of age or older having a venereal disease may now give consent to the furnishing of medical care related to the diagnosis or treatment of such disease. All such cases shall be reported by the physician to the State Department of Public Health or the local Board of Health. Any physician providing diagnosis or treatment for a minor having a venereal disease may in his discretion inform the parent or guardian of such minor as to the treatment given or needed.

5. Physicians are now specifically authorized to provide birth control services including medical and pharmacological treatment and information to any minor:

- a) who is married; or
- b) who is a parent; or

- c) who is pregnant; or
- d) who has the consent of his parent or legal guardian; or
- e) as to whom the failure to provide such services would create a serious health hazard; or
- f) who is referred for such services by a physician, clergyman or a planned parenthood agency.

### **Employment Contract Between Physician and Patient**

The relationship between a physician and a patient is one of contractual relationship and, therefore, a physician is under no legal requirement to accept anyone as a patient unless he so desires. This rule is true in the case of an emergency even though no other physician is available.

Legally, a physician has the right to refuse treatment in the case of an accident or other emergency and could not in any way be held liable for refusing to administer aid. (*This is strictly the legal answer and does not involve the moral or ethical question.*) The rendering of such services as may be necessary in the case of an emergency does not of itself give rise to the relationship of physician and patient and the physician is under no obligation to continue treatment beyond the emergency.

The physician in rendering emergency treatment, however, must use the same degree of skill and care as required in other cases, taking into consideration conditions at the scene of the accident.

### **Continuation of Treatment**

A physician or surgeon, on undertaking an operation or treatment, is under the duty, in the absence of an agreement limiting the service, of continuing his attendance, after the operation or first treatments, as long as the case requires attention; and a surgeon, in his treatment subsequent to an operation, is required to exercise reasonable and ordinary skill and care.

The failure to give needed continued care under an obligation to do so constitutes negligence or malpractice. The obligation of continuing attention can be terminated only by the cessation of the necessity which gave rise to the relationship of physician and patient, by mutual consent of the parties, by the discharge of the physician by the patient, or by the physician's withdrawing from the case after giving the patient reasonable notice so as to enable him to secure other medical attendance.

A physician has the legal right to withdraw from a case if the patient breaks the contract by failure to follow the medical advice or treatment and direction of the physician, but the relationship cannot be terminated until the physician has advised the patient of his withdrawal from the case and has allowed the patient a



reasonable length of time to procure another doctor.

### Written Notice

What is reasonable notice to the patient depends upon the circumstances of each case. Factors which must be taken into consideration are the condition of the patient, the size of the community, and the availability of other physicians. In order to be completely safe, prior to withdrawal from the case, the physician should advise the patient in writing of his intent to withdraw, his reasons therefor, and the fact that he will make available the patient's case history and information regarding diagnosis and treatment to the new physician when selected by the patient. Should the patient return to the original physician stating that he has been unable to procure other medical aid, treatment should not be refused until a replacement has been obtained.

A physician has the right to leave his practice temporarily if he makes provisions for the attendance of a competent physician during his absence. This notice, which again preferably should be in writing, should be in sufficient time so that patients can obtain replacements of their own choice if they do not desire to consult the physician temporarily handling the practice of the absent physician.

### GOOD SAMARITAN ACT

The 1965 Legislature passed the so-called "Good Samaritan Bill" providing that any physician, who in good faith, provides emergency care without a fee at the scene of a motor vehicle accident or in case of nuclear attack shall not as a result of his acts or omissions, except in the case of gross willful or wanton negligence, be liable for damages. (Paragraph 2a of Chapter 91, Illinois Revised Statutes, 1967.)

In 1969 this Act was further amended to extend the physician's immunity to any type of accident.

### HOSPITAL PATIENT RECORDS

The 1969 session of the General Assembly passed a new act which provides that all private or public hospitals shall, upon the demand of any patient, allow his physician or attorney to examine his hospital records and to make copies thereof. The only exception is in connection with records relating to psychiatric care. Demands for such records must be in writing and shall be delivered to the administrator of the hospital.

### HOSPITAL EMERGENCY ROOMS

For many years Illinois law has required that both public and private hospitals, where surgi-

cal operations are performed, must provide emergency medical treatment or first aid to any person who applies for same in the case of injury or acute medical condition where the same is liable to cause death or severe injury or serious illness. This act provides penalties for non-compliance.

In the 1969 session of the Legislature this act was amended by Senate Bill 568 by allowing two or more hospitals to combine for the purpose of providing this emergency service upon an area wide or community basis but with the requirement that the plan of consolidation be reduced to writing and approved by the Illinois Department of Public Health prior to its implementation.

### INTERNAL REVENUE CODE

It should be evident to the busy physician that it is just as unwise for him to be his own tax consultant as it is for every man to be his own doctor. The physician is well aware that in seeking to keep abreast of all of the ramifications and developments of modern medicine, he has a burden that is becoming increasingly difficult to sustain and that he has very little time to devote to subjects as complex as taxation, which is rightfully the province of his accountant and lawyer.

Taxation in the United States is complex and many tax matters have no particular application to the medical profession as such. However, the doctor as a citizen should be aware that he is greatly affected by a subject so varied and so complicated that the statutes themselves require some 1,500 pages to be set forth. And he should know that sections 1(a) through 8023(b) are printed in a size of type that should be of some benefit in fees to practitioners who concern themselves with the human eye. Surely the point that physicians are well advised to place their problems with accounting and legal advisors is further exemplified by such facts as the following:

Regulations implementing the Internal Revenue Act require some 9,700 pages for them to be spelled out and that, in order to designate the different regulations, the government needs to entitle the regulations as Regulation Section 1.0-1 through Regulation Section 301.770-11.

Just as the patient would be so much better served if he saw his doctor regularly before difficulties become advanced, so the physician's interests would be better served if he would seek advice on income and estate tax problems before the fact, rather than after problems have arisen.

### PROCEDURES AND REPORTS IN CONTROL OF NARCOTIC DRUGS

Physicians are subject to control by both the state of Illinois and the federal government in relation to narcotic drugs. The numerous provisions of the federal regulations are set forth in a fairly lengthy pamphlet entitled, "Regulations

No. 5 Relating to the Importation, Manufacture, Production, Sale, etc., of Opium, Coca Leaves, Isonipecaïne or Opiates," which was reprinted April 1, 1957, and is available at a cost of 45 cents through the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. This is published by the Bureau of Narcotics of the U. S. Treasury Department.

The state of Illinois' "Uniform Narcotic Drug Act" has been in effect since Jan. 1, 1958. It is found in paragraphs 22-1 through 22-49, inclusive, Chapter 38 of Illinois Revised Statutes, 1967. The Division of Narcotic Control's current rules and regulations to implement the Act have been in effect since Apr. 1, 1960. They cover such matters as prescriptions and official forms therefor, emergencies excusing use of other than official prescription forms, reporting of loss or theft of such prescription blanks, records to be kept by the physician, dispensing of hypodermic syringes and needles, prescribing procedures in hospitals, and other subjects related to narcotic drugs. The Act and the rules and regulations are available at no cost through the Division of Narcotic Control, 623 E. Adams St., Springfield.

Further, the state of Illinois has had in effect since Jan. 1, 1960, a "Uniform Drug, Device and Cosmetic Act." Its rules and regulations control such things as the keeping of adequate records, for a period of two years, of all purchases and dispositions of dangerous drugs as such drugs are defined by the Act. A publication containing the Act and the pursuant rules and regulations is also available through the Division of Narcotic Control in Springfield.

All physicians are urged to have in their possession copies of both the state and federal narcotic control acts and the rules and regulations implementing them. As these laws and regulations are changed from time to time, every effort should be made to have the current rules.

## PROCEDURES AND REPORTS AS TO COMMUNICABLE DISEASES

In order to be conversant with the presently governing rules and regulations as to the control of communicable diseases and the physician's duties as to reports and procedures in relation to these afflictions, it is suggested that the physician apply to the Department of Public Health of the State of Illinois at Room 500, State Office Building, Springfield, for the publication entitled, "Rules and Regulations for the Control of Communicable Diseases," which was revised July 1, 1965.

## ANATOMICAL GIFT ACT

The law in the State of Illinois as to the right of an individual to leave his body or particular parts thereof for medical science by will, written statement or action by the next of kin

has been implemented by Senate Bill 99 adopted by the 1969 Legislature. This new act which repeals the prior act on this subject is as follows:

Section 1. This Act may be cited as the Uniform Anatomical Gift Act.

Section 2.

(a) "Bank or storage facility" means a facility licensed, accredited or approved under the laws of any state for storage of human bodies or parts thereof.

(b) "Decedent" means a deceased individual and includes a stillborn infant or fetus.

(c) "Donor" means an individual who makes a gift of all or parts of his body.

(d) "Hospital" means a hospital licensed, accredited or approved under the laws of any state; and includes a hospital operated by the United States government, a state, or a subdivision thereof, although not required to be licensed under state laws.

(e) "Part" means organs, tissues, eyes, bones, arteries, blood, other fluids and any other portions of a human body.

(f) "Person" means an individual, corporation, government or governmental subdivision or agency, business trust, estate, trust, partnership or association or any other legal entity.

(g) "Physician" or "surgeon" means a physician or surgeon licensed or authorized to practice medicine in all of its branches under the laws of any state.

(h) "State" includes any state, district, commonwealth, territory, insular possession, and any other area subject to the legislative authority of the United States of America.

Section 3.

(a) Any individual of sound mind and being an adult may give all or any part of his body for any purpose specified in Section 4, the gift to take effect upon death, or if no such gift is so made, then

(b) The following persons who are living at the time of the gift, in the order of priority stated, in the absence of a gift made pursuant to Section 5, may give all or any part of the decedent's body for any purpose specified in Section 4:

- (1) the spouse and adult sons and daughters,
- (2) both parents,
- (3) adult brothers and sisters,
- (4) a guardian of the person of the decedent at the time of his death,
- (5) any person authorized or under obligation to dispose of the body.

(c) If the donee has actual notice of contrary indications by the decedent or actual notice that a gift by a member of a class is opposed by a member of the same or a prior class, the donee shall not accept the gift. The persons authorized by subsection (b) may make the gift after or immediately before death.

(d) A gift of all or part of a body authorizes any examination necessary to assure medical acceptability of the gift for the purposes intended.

(e) The rights of the donee created by the gifts are paramount to the rights of others except as provided by Section 8 (d).

Section 4.

The following persons may become donees of gifts of bodies or parts thereof for the purposes stated:

- (1) any hospital, surgeon, or physician, for medical or dental education, research, advancement of medical or dental science, therapy, or transplantation; or
- (2) any accredited medical, chiropractic, mor-



tuary or dental school, college or university for education, research, advancement of medical or dental science, or therapy; or

(3) any bank or storage facility, for medical or dental education, research, advancement of medical or dental science, therapy, or transplantation; or

(4) any specified individual for therapy or transplantation needed by him, or for any other purpose.

#### Section 5.

(a) A gift of all or part of the body under Section 3 (a) may be made by will. The gift becomes effective upon the death of the testator without waiting for probate. If the will is not probated, or if it is declared invalid for testamentary purposes, the gift, to the extent that it has been acted upon in good faith, is nevertheless valid and effective.

(b) A gift of all or part of the body under Section 3 (a) may also be made by a written, signed document other than a will. The gift becomes effective upon the death of the donor. The document, which may be a card designed to be carried on the person, must be signed by the donor in the presence of 2 witnesses who must sign the document in his presence and who thereby certify that he was of sound mind and memory and free from any undue influence and knows the objects of his bounty and affection. Delivery of the document of gift during the donor's lifetime is not necessary to make the gift valid.

(c) The gift may be made to a specified donee or without specifying a donee. If the latter, the gift may be accepted by the attending physician as donee upon or following death. If the gift is made to a specific donee who is not available at the time and place of death, the attending physician upon or following death, in the absence of any expressed indication that the donor desired otherwise, may accept the gift as donee. The physician who becomes a donee under this subsection shall not participate either physically or financially in the procedures for removing or transplanting a part.

(d) Notwithstanding Section 8 (b), the donor may designate in his will, card, or other document of gift the surgeon or physician to carry out the appropriate procedures. In the absence of a designation or if the designee is not available, the donee or other person authorized to accept the gift may employ or authorize any surgeon or physician for the purpose.

(e) Any gift by a person designated in Section 3 (b) shall be made by a document, signed by him or made by his telegraphic, recorded telephonic, or other recorded message.

Section 6. If the gift is made by the donor to a specified donee, the will, card, or other document, or an executed copy thereof, may be delivered to the donee to expedite the appropriate procedures immediately after death. Delivery is not necessary to the validity of the gift. The will, card, or other document, or an executed copy thereof, may be deposited in any hospital, bank or storage facility, or registry office that accepts it for safekeeping or for facilitation of procedures after death. On request of any interested party upon or after the donor's death, the person in possession shall produce the document for examination.

#### Section 7.

(a) If the will, card, or other document or executed copy thereof, has been delivered to a specified donee, the donor may amend or revoke the gift by:

(1) the execution and delivery to the donee of a signed statement witnessed and certified as provided in Section 5 (b)

(2) a signed card or document found on his person, or in his effects, executed at a date subsequent to the date the original gift was made and witnessed and certified as provided in Section 5 (b)

(b) Any document of gift which has not been delivered to the donee may be revoked by the donor in the manner set out in subsection (a).

(c) Any gift made by a will may also be amended or revoked in the manner provided for amendment or revocation of wills or as provided in subsection (a).

#### Section 8.

(a) The donee may accept or reject the gift. If the donee accepts a gift of the entire body, he may, subject to the terms of the gift, authorize embalming and the use of the body in funeral services. If the gift is a part of the body, the donee, upon the death of the donor and prior to embalming, shall cause the part to be removed without unnecessary mutilation and without undue delay in the release of the body for the purpose of final disposition. After removal of the part, custody of the remainder of the body vests in the surviving spouse, next of kin, or other persons under obligation to dispose of the body.

(b) The time of death shall be determined by a physician who attends the donor at his death, or, if none, the physician who certifies the death. The physician shall not participate in the procedures for removing or transplanting a part.

(c) A person who acts in good faith in accord with the terms of this Act or the anatomical gift laws of another state or a foreign country is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for his act.

(d) This Act is subject to the provisions of "An Act to revise the law in relation to coroners," approved February 6, 1874, as now or hereafter amended, to the laws of this State prescribing powers and duties with respect to autopsies, and to the statutes, rules, and regulations of this State with respect to the transportation and disposition of deceased human bodies.

Section 9. This Act shall be so construed as to effectuate its general purpose to make uniform the law of those states which enact it.

Section 10. Section 42a of the "Prohate Act," approved July 24, 1939, as amended, is repealed.

Section 11. This Act shall take effect October 1, 1969.

The Illinois State Medical Society and the Illinois Hospital Association are presently working upon forms which may be used by both a living donor and by next of kin, in order to make anatomical gifts.

## AUTOPSY

In Illinois, the heirs and next of kin can bring an action for mutilation of the body in those cases where an autopsy is performed without authority or permission. In order to avoid the possibility of liability, autopsies should only be performed, in Illinois, when ordered by the coroner or upon written consent given by the next of kin. The coroner may order an autopsy directly against the wishes of the next of kin.

## MEDICAL CORPORATIONS

In 1963 the Illinois Legislature for the first time authorized the formation of medical corporations (Paragraph 631 through 647 Chapter 32 Illinois Revised Statutes, 1967). Under this act one or more physicians licensed to practice medicine may organize as an Illinois business corporation. All officers, directors and shareholders of the corporation must be licensed under the Medical Practice Act.

After the passage of this Act, Internal Revenue took the position that physicians were not entitled to any tax benefits thereunder. In those cases appealed, the courts ruled that such benefits should be allowed.

In the summer of 1969 Internal Revenue retreated from this position and now is holding that medical corporations authorized under state law are valid and that the tax benefits accrue to the members.

## INTERPROFESSIONAL CODE FOR PHYSICIANS AND LAWYERS OF ILLINOIS

The Interprofessional Code for Physicians and Lawyers of Illinois was drafted by a special committee on medical-legal cooperation of the Illinois State Bar Association and the Illinois State Medical Society to serve as a guide for physicians

and lawyers, which code has been approved by the governing body of both the Illinois State Bar Association and the Illinois State Medical Society.

The preamble of this code which expresses the purposes thereof is as follows:

"The Purposes of this Code are to establish standards of practice and of ethical conduct for physicians and lawyers in those areas in civil cases where there is and will continue to be an inter-relationship of medicine and law, and thereby to improve the practical working relationships of the two professions, to protect the legitimate interests and the rights of the patient-client, of the physician, the lawyer, and of society, and thereby to help advance the more effective administration of justice.

"The provisions of the Code constitute recognition that the members of each profession have an obligation not only to the individual, who obtains their advice and assistance but also to the community and society as a whole, and to all other members of their own professions. The objectives of the Code can be achieved only if the members of both professions acquaint themselves with these standards of practice and follow them, subject to rules of law and principles of medical and legal ethics."

Due to space limitations the Code is not being printed in its entirety but copies may be obtained from the office of the Illinois State Medical Society.

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Due to an error in source reporting, some omissions occurred in the listings of various schools providing training in paramedical fields. In addition, some erroneous listings were included. These pertain to pages 417 and 418 of the "Reference Issue." It is suggested that the following pages be used to correct existing copy or that these pages be removed and tipped into the October Issue.

## MEDICAL SCHOOLS IN THE STATE OF ILLINOIS

Chicago Medical School  
2020 W. Odgen Ave.

Chicago, Ill. 60612

Leroy Levitt, M.D., Dean  
226-4100

University of Chicago Pritzker School of Medicine  
950 E. 59th St.

Chicago, Ill. 60637

Leon O. Jacobson, M.D., Dean  
MU 4-6100  
MU 3-0800

Northwestern University Medical School  
303 E. Chicago Avenue

Chicago, Ill. 60611

Richard H. Young, M.D., Dean  
649-8649

University of Illinois College of Medicine  
1853 W. Polk St.

P.O. Box 6998

Chicago, Ill. 60680

William Grove, M.D., Dean  
663-3500

Stritch School of Medicine—Loyola University  
2160 S. First Ave., Maywood, Ill. 60153  
531-3000; 921-2610

John G. Masterson, M.D., Dean  
706 S. Wolcott Ave.  
Chicago, Ill. 60612  
SE 3-8040



## APPROVED SCHOOLS OF MEDICAL TECHNOLOGY

AURORA—Copley Memorial Hospital  
 BELLEVILLE—St. Elizabeth Hospital  
 BLUE ISLAND—St. Francis Hospital  
 CHAMPAIGN—Burnham City Hospital  
 CHICAGO—Augustana Hospital, Chicago Wesley Memorial Hospital, Edgewater Hospital, Grant Hospital of Chicago, Holy Cross Hospital, Illinois Masonic Hospital, Louis A. Weiss Memorial Hospital, Mercy Hospital, Michael Reese Hospital, Mount Sinai Hospital, Northwestern University Medical School (Passavant Memorial Hospital), Presbyterian-St. Luke's Hospital, St. Anne's Hospital, St. Anthony dePadua Hospital, St. Joseph Hospital, St. Mary of Nazareth Hospital, University of Illinois School of Associated Medical Sciences and Veterans Administration Research Hospital.  
 CHICAGO HEIGHTS—St. James Hospital  
 DANVILLE—Lake View Memorial Hospital  
 DECATUR—Decatur Memorial Hospital and St. Mary's Hospital  
 ELK GROVE VILLAGE—St. Alexis Hospital  
 EVANSTON—Evanston Hospital  
 St. Francis Hospital  
 EVERGREEN PARK—Little Company of Mary Hospital  
 FREEPORT—Freeport Memorial Hospital  
 GENEVA—Community Hospital  
 GREAT LAKES—U.S. Naval Hospital  
 (Initial Approval)  
 HARVEY—Ingalls Memorial Hospital  
 HINSDALE—Hinsdale Sanitarium and Hospital  
 JOLIET—Silver Cross Hospital  
 St. Joseph Hospital  
 MOLINE—Moline Public Hospital  
 OAK LAWN—Christ Community Hospital  
 OAK PARK—West Suburban Hospital  
 PARK RIDGE—Lutheran General Hospital  
 PEORIA—Methodist Hospital and St. Francis Hospital  
 QUINCY—St. Mary's Hospital  
 ROCKFORD—Rockford Memorial Hospital, St. Anthony Hospital and Swedish-American Hospital  
 ROCK ISLAND—St. Anthony Hospital  
 SPRINGFIELD—Memorial Hospital  
 St. John's Hospital  
 URBANA—Carle Foundation Hospital  
 WAUKEGAN—St. Therese's Hospital  
 WINFIELD—Central Dupage Hospital

## APPROVED SCHOOLS OF CERTIFIED LABORATORY ASSISTANTS

ALTON—Alton Memorial Hospital  
 CHICAGO—St. Elizabeth's Hospital, Swedish Covenant Hospital and Veterans Administration West Side Hospital.  
 DANVILLE—St. Elizabeth Hospital  
 DIXON—Sauk Valley College  
 ELGIN—Sherman Hospital  
 OAK LAWN—Moraine Valley Community College  
 OAK PARK—Oak Park Hospital  
 QUINCY—Blessing Hospital

## APPROVED SCHOOLS OF INHALATION THERAPY

CHICAGO—Cook County Hospital, Edgewater Hospital, Northwestern University Medical Center, University of Chicago Hospitals  
 DECATUR—St. Mary's Hospital  
 HINES—Veterans Administration Hospital  
 MELROSE PARK—Gottlieb Memorial Hospital  
 MOLINE—Lutheran Hospital  
 SPRINGFIELD—Memorial Hospital, St. John's Hospital

## APPROVED SCHOOLS OF CYTOTECHNOLOGY

CHICAGO—Michael Reese Hospital and Medical Center  
 Mount Sinai Hospital Medical Center  
 University of Chicago Hospitals and Clinics

## APPROVED SCHOOLS FOR MEDICAL RECORD LIBRARIANS

CHICAGO—University of Illinois at the Medical Center

## APPROVED COURSE IN OCCUPATIONAL THERAPY

CHICAGO—University of Illinois College of Medicine

## APPROVED SCHOOL OF PHYSICAL THERAPY

CHICAGO—Northwestern University Medical School

## APPROVED SCHOOLS OF X-RAY TECHNOLOGY

ARLINGTON HTS.—Northwest Community Hospital	DIXON—Dixon Public Hospital
AURORA—Copley Memorial Hospital St. Joseph Mercy Hospital	EAST ST. LOUIS—Centreville Township Hospital
BLOOMINGTON—Bloomington-Normal Hospital	ELGIN—Saint Joseph Hospital
BLUE ISLAND—St. Francis Hospital	ELMHURST—Memorial Hospital of DuPage County
CENTRALIA—St. Mary's Hospital	EVANSTON—Evanston Hospital St. Francis Hospital
CHAMPAIGN—Burnham City Hospital	EVERGREEN PARK—Little Company of Mary Hospital
CHICAGO—Chicago Wesley Memorial Hospital Cook County Graduate School of Medicine Edgewater Hospital Englewood Hospital Franklin Boulevard Community Hospital Grant Hospital Henrotin Hospital Illinois Masonic Hospital Louis A. Weiss Memorial Hospital Michael Reese Hospital Mt. Sinai Hospital Norwegian-American Hospital Presbyterian-St. Luke's Hospital Provident Hospital Ravenswood Hospital Roseland Community Hospital St. Anne's Hospital St. Bernard's Hospital St. Elizabeth's Hospital St. Joseph Hospital St. Mary of Nazareth Hospital South Chicago Community Hospital Woodlawn Hospital	GREAT LAKES—U.S. Naval Hospital HARVEY—Ingalls Memorial Hospital HINES—Veterans Administration Hospital HINSDALE—Hinsdale Sanitarium and Hospital JOLIET—Silver Cross Hospital St. Joseph Hospital KANKAKEE—St. Mary's Hospital KEWANEE—Kewanee Public Hospital MOLINE—Luthern Hospital Moline Public Hospital
DANVILLE—Lake View Memorial Hospital	NORTHLAKE—Triton College (Initial Approval)
DECATUR—Decatur Memorial Hospital	OAK PARK—West Suburban Hospital OLNEY—Richard Memorial Hospital PARK RIDGE—Lutheran General Hospital PEORIA—Methodist Hospital of Central Illinois St. Francis Hospital QUINCY—Blessing Hospital St. Mary Hospital ROCKFORD—Rockford Memorial Hospital St. Anthony Hospital Swedish-American Hospital ROCK ISLAND—St. Anthony's Hospital SKOKIE—Skokie Valley Community Hospital SPRINGFIELD—Memorial Hospital St. John's Hospital URBANA—Carle Foundation Hospital Mercy Hospital

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The following corrections should be made in the "Reference Issue":

**page 371:**

*South Chicago Branch*

Secretary-Treasurer should read:

Thomas S. Bernat, 621 W. 26th St.,  
Chicago 60616

**page 375:**

WASHINGTON COUNTY

President should read:

Jerry L. Beguelin, Irvington Medical  
Center, Irvington 62848

**page 387:**

COMMITTEE ON CHILD HEALTH

add: Irving Abrams, 6342 N. Sheridan Rd.,  
Chicago 60626

**page 469:**

*Extended Care Facilities*

**FRANKLIN GROVE**

Franklin Grove Nursing Center (70)



# Rx Products Index

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Eli Lilly & Company	Mead Johnson Laboratories
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Parke, Davis & Co.	G. D. Searle & Co.
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Donnagel/Robitussin .....667-669-749	NTZ Nasal Spray .....646
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Arnar-Stone Laboratories, Inc.	Mead Johnson Laboratories

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## MANUSCRIPT INFORMATION

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed.

Manuscripts should be typed, double spaced, and submitted in duplicate, one original and one carbon. An article should not exceed **12 to 16 manuscript pages**, (including illustrations) and should be briefer if possible.

References should be numbered and conform to the following style in the order given: name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Make drawings and charts in black ink. If photographs are submitted, send black and white glossies. Number illustrations consecutively and indicate their place in the text. Number, indicate the top and place the author's name on the back of each illustration.

Address manuscripts to:

T. R. Van Dellen, M.D., Editor  
Illinois Medical Journal  
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**References:** (1) Fazekas, J. F.; Alman, R. W.; Ticktin, H. E.; Ehrmantraut, W. R., and Savarese, C. J.: *Angiology* 15:No. 2 (Feb.) 1964. (2) Horton, G. E., and Johnson, P. C., Jr.: *Angiology* 15:70-74 (Feb.) 1964. (3) Clarkson, I. S., and LePere, D. M.: *Angiology* 11:190-192 (June) 1960. (4) Dhymiotis, A. D., and Whittier, J. R.: *Current Therapeutic Research* 4:124-128 (April) 1962. (5) Whittier, J. R.: *Angiology* 15:82-87 (Feb.) 1964.

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## Membership Forum

### **IMPAC Membership**

The final issue of "On The Legislative Scene," plus subsequent issues of "Pulse," have carried, or will carry, reports of Legislative activity during the 76th General Assembly. Regardless of the specific area or field in which many of us practice or specialize, it should be obvious that the legislation enacted has a direct effect upon all.

With the signing into law of the bill appropriating 6.1 million dollars to the Chicago Medical School, medicine can take pride in the fact that it was the prime mover behind the legislation. The new law which requires that any state-supported Medical School establish a Department of General Practice by next year is another response to the needs of the people, fostered by the ISMS. On the other hand, the defeat of an insidious piece of legislation allowing Chiropractors to give complete school physicals was brought about

solely through the efforts of medicine. These are only three of the literally hundreds of legislative measures introduced during the recent sessions—and on which physicians took a position. That medicine had a successful session is an accepted fact.

Perhaps the single most important reason for that success is—we had the ear of most legislators. That ear was open and receptive because when the chips were down during election campaigns, good legislators had the ear of IMPAC. And, those good legislators came from both sides of the aisle, Democrat as well as Republican.

But, 1970 is another election year—and a big one at that. IMPAC is counted on! It is a dynamic Force! It is responsive! Let it work for you! Let it work for medicine. Join.

Philip Thomsen,  
Past-President, ISMS

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## Meeting Memos

### **Dec. 26-31—American Association for the Advancement of Science**

*136th Meeting*  
Boston, Massachusetts

### **Jan. 4-17, 1970—American Cancer Society**

*Pacific Cancer Conference*  
Kauai and Maui, Hawaii

### **Jan. 8-11—The University of Miami, School of Medicine & The University of Florida, School of Medicine**

*The Seventh Annual Postgraduate Seminar*  
Eden Roc Hotel, Miami Beach, Florida  
"Advances In Respiratory Care and Physiology"

### **Jan. 14—Frontiers of Medicine Series University of Chicago**

*Recent Progress in Human Genetics*  
Center for Continuing Education  
1307 East 60th Street, Chicago

### **Jan. 14-15—The Cleveland Clinic Educational Foundation**

*Selected Problems in General Surgery & Vascular Surgery*  
2020 East 93rd St., Cleveland, Ohio

### **Jan. 20—The Chicago Pediatric Society**

*Ambulatory Pediatric Services*  
Pioneer Court, Chicago

### **Jan. 21—University of Kentucky College of Medicine**

*Current Concepts in Gastro-Intestinal & Biliary Tract Surgery*  
Albert B. Chandler Medical Center  
University of Kentucky  
Lexington, Ky.

### **Jan. 23-25—Children's Hospital of Los Angeles**

*8th Clinical Conference in Pediatric Anesthesiology*  
Children's Hospital of Los Angeles  
4650 Sunset Blvd., Los Angeles, Calif.

The heavy majority favoring the formation of a state disciplinary board provides ISMS with the impetus to pursue this issue further. Future study of the proposal will involve appropriate state agencies and legal authorities.

A breakdown of the survey response, by age and type of practice, reveals that the strongest support for the proposal comes from younger doctors, under 40 years old, and from specialists, rather than general practitioners.

While the concept of a state disciplinary authority was upheld, another proposal for policing the profession received a mixed reaction. The survey asked:

Should ISMS contract legal services for the purpose of investigating doctors (including non-members) and presenting evidence of suspected misconduct to the state? .....	<b>Yes 52%</b>
	<b>No 48%</b>

Action was directed, however, on still another proposal to insure professional discipline. The proposal stemmed from the often-heard statement that the public is not sufficiently informed on matters of medical ethics, and therefore does not know when or how to lodge a complaint. We asked for your viewpoint on the question:

Should ISMS inform the public—through an education program—of what factors constitute unreasonable fees or unethical practices? .....	<b>Yes 75%</b>
	<b>No 25%</b>

The response to the question serves as a mandate to ISMS to draw up plans for an educational program of this nature. A breakdown of the response shows heaviest backing from Chicago area doctors.

## The Power of Peer Review

Although the label “bad apple” is usually tagged to the physician who is deliberately negligent, the doctor who practices slipshod medicine because of advanced age or chronic illness also poses a serious problem.

It has been suggested that medical society peer review committees lack the power—or the willingness—to censure a doctor unless a serious charge of misconduct is brought against him. Thus the aged surgeon with failing coordination or the physician addicted to drugs or alcohol may escape the scrutiny of peer review committees, even though the medical community may be well aware of the doctor’s incapacities.

The survey asked you if the role of peer review committees should be more clearly specified in such cases:

Should ISMS and county medical societies require local peer reviews of physicians when evidence indicates incompetence due to age, sickness, or other causes? .....	<b>Yes 82%</b>
	<b>No 18%</b>



As would be expected, younger doctors came out strongest on this issue, favoring the proposal by nearly 10 to 1. Specialists gave a heavier endorsement than general practitioners. No appreciable difference was noted between the response of downstate and Chicago area doctors.

The survey also indicated that many doctors want to strengthen the disciplinary weapons available to the peer review committees. Although expulsion or suspension from the medical society may deprive the censured doctor of certain privileges, he may still practice medicine so long as he holds a license. Therefore, the survey asked if peer review committees should take their disciplinary actions a step farther:

If peer review determines that a physician is incapable of practicing medicine, should the county or state medical society recommend to the Department of Registration and Education that his license be restricted or withdrawn? .....	Yes 76%
	No 24%

The most vigorous endorsement of this proposal comes from younger doctors and specialists. Downstate physicians favored it slightly more than Chicago area doctors.

The response of this and the previous question will provide valuable direction to peer review committees on the county, district and state level. The survey results will also be emphasized in an ISMS conference on peer review scheduled February 8, 1970. All county and district committees, as well as county medical society officers, will be urged to attend this important one-day meeting.

**Participation in Continuing Education**

"More often than not," wrote one rural doctor on his survey questionnaire, "the doctor who is incapable of practicing medicine, has been given no opportunity to improve, even though he may be willing to do so."



The physician's statement capsulizes what many authorities believe to be one of the greatest problems in continuing medical education. Too many patients and too little time prevents many doctors from updating their medical knowledge, despite their desire to provide their patients with the best possible care.

Rural physicians are especially hard put, because most continuing education courses are held in urban areas. Thus a doctor's participation in a continuing education program may deprive a community of much-needed medical services for some period of time.

Despite these obstacles, Illinois doctors do find time to take part in continuing education activities, as shown in the question:

Are you now participating in a formal continuing medical education program .....	<b>Yes 60%</b>
	<b>No 40%</b>

A breakdown of the response points out that Chicago area doctors are more able to participate in continuing education programs than downstate physicians. There was practically no difference in participation between GPs and specialists.

The most important factor in determining participation seems to be age. Whereas 65 percent of the doctors who are 55 years old or younger participate in some sort of formal education program, only 52 percent of physicians over 55 years old take part in such activities.

## Making Continuing Education Mandatory

The increasing intervention of government into private medicine has brought suggestions that the responsibility for maintaining professional standards and medical knowledge be taken out of the hands of physicians. In this regard, the President's Commission on Health Manpower has recommended the compulsory relicensure of all physicians.

Opponents of this proposal argue that there are other means of insuring that all physicians maintain up-to-date medical knowledge. These proposals center around tying continuing education to medical organization or hospital staff membership. We asked your opinions of these alternatives in this question:

Because of the rapid expansion of medical knowledge, some observers have urged compulsory relicensure examinations for physicians. As an alternative, would you favor participation in a continuing medical education program as a requirement for:

Membership in your specialty society or AAGP? .....	<b>Yes 74%</b>
	<b>No 26%</b>
Membership in the Illinois State Medical Society? .....	<b>Yes 51%</b>
	<b>No 49%</b>
Reappointment to your hospital staff? .....	<b>Yes 57%</b>
	<b>No 43%</b>



The response indicates that most doctors favor participation in a continuing education program as a requirement for membership in their specialty society or AAGP. The idea of linking such participation to ISMS or hospital staff membership did not receive any decisive endorsement.

The survey showed that most doctors are against the concept of periodic examinations as proposed in this question:

As an alternative to mandatory participation in a continuing medical education program for membership in the above groups, would you favor periodic examinations conducted by your specialty society or AAGP? .....	Yes 27%
	No 73%

The results of this and other survey questions relating to continuing medical education are being carefully studied by ISMS. Dr. Edward W. Cannady, ISMS president, currently is discussing the formation of a statewide continuing education effort with the University of Illinois.

Tentative plans call for the establishment of a council on continuing medical education that would set forth policy. Both ISMS and cooperating Illinois medical schools would be represented on the Council.

According to the proposal, the Center for Education Development in the U. of I. College of Medicine would be responsible for translating policy guidelines into specific local, regional and statewide programs. Illinois Regional Medical Program and cooperating medical schools would also be involved in program planning.

The analysis of the results of the **Illinois Medical Journal** Membership Opinion Survey will be concluded in the January issue. It will treat legislative issues.

**YOUR ISMS INSURANCE QUESTIONS**

**QUESTION:** Are my employees covered for professional liability under my ISMS policy?

**ANSWER:** You are covered for your employees professional acts while in your employ. However, your employees should carry their own professional liability policy to protect themselves as individuals.

*Do you have a question of general interest on any ISMS-sponsored insurance program: Retirement Investment, Keogh, Group Disability, Group Major Medical, Professional Liability (Malpractice)? Send it to this column: "Your ISMS Insurance Questions," Illinois Medical Journal, 360 N. Michigan Avenue, Chicago, Ill. 60601. The column is a service of the ISMS Committee on Medical Economics and Insurance.*

# SOCIO ECONOMIC *news*

*A service of the Public Relations and Economics Division*

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By JOSEPH J. LOTHARIUS

## **Peer Review Seminar In Chicago—Feb. 8**

Guidelines for establishing effective peer review committees on the local level will be unveiled at the ISMS Leadership Conference February 8. The one-day event will be held at Chicago's Sheraton-Blackstone Hotel. Representatives from district and county peer review committees and officers from every county medical society are urged to attend this important meeting. A panel discussion on latest developments in the crucial malpractice issue will also be offered. Program details will be mailed soon.



## **Use Caution In Pre- scribing P.T. Services Under Medicare**

Illinois physicians prescribing physical therapy services should be fully aware of the coverage for such services under medicare. The ISMS Rehabilitation Services Committee has been notified by medicare intermediaries that they have received numerous billings that indicate improper prescribing or delivery of physical therapy services. MD's are urged to obtain copies of "Bulletin from Blue Cross" (Vol. 21, August 25, 1969) which outlines Social Security Administration regulations on physical therapy services under medicare. Write: Blue Cross Bulletin, Blue Cross, 222 North Dearborn St., Chicago, Ill. 60601.



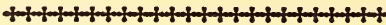
## **Physical Therapists Cannot Practice Medicine**

The ISMS Rehabilitation Services Committee reminds physicians that paramedical personnel, including physical therapists, should never be placed in a position where they are encouraged or permitted to practice medicine. This requires the doctor to be knowledgeable about the various modes of physical therapy in order to properly prescribe and evaluate the progress of his patient. The AMA House of Delegates specifically addressed this problem in a resolution, part of which reads: "Resolved . . . that the practice of medicine, which includes the diagnosis and treatment of the patient and his diseases, be preserved as the responsibility of the physician, and that paramedical personnel not be placed in the position of practicing medicine whether by consent, design or contract.



**Hospitals Take Biggest  
\$\$\$\$ Bite**

Although physician's fees increased about 45 percent between 1958 and 1968, basic daily hospital charges (which include room, board and routine nursing care) have shot up 126 percent, according to ISMS President, Dr. Edward W. Cannady, in a recently published series of articles on rising health costs. Not only have hospital charges grown faster than all other medical prices, they also take the biggest bite out of the consumer's health care dollar. For example, out of each dollar the U.S. consumer spent on personal health care in 1968, 42 cents went for hospital care, while 23 cents went for physicians' services, 7 cents was paid to dentists, 12 cents was paid for drugs, and 16 cents for miscellaneous goods and services.



**TV Documentary On  
MD Shortage Planned**

A television documentary on the physician shortage in Illinois is scheduled to be shown on Sunday, December 21, at 10:30 P.M. on WMAQ-TV (Channel 5 Chicago). Dr. Philip G. Thomsen, immediate past president of ISMS will have a "starring role" in the one-half-hour program that was produced in cooperation with ISMS.



**FACTS ON FEES**

Small, eye-catching pamphlets designed to tell patients the facts behind physicians' fees are now available free to ISMS members. These messages may accompany bills or be made available in waiting rooms.

The outside of the pamphlet consists of a large green dollar sign. Inside, a headline reads: "What you pay your doctor . . . pays for many things." A simple circular graph shows that much of the patient's dollar goes for "hidden expenses." For example, out of each dollar paid to the solo practitioner, 15c goes for office salaries, 5c for rent, 5c for equipment and supplies, and 17c for miscellaneous costs. Since expenses for group and solo practices differ, there are two versions of the pamphlet.

When ordering, *please specify whether you are in group or solo practice.*

-----  
**"Facts on Fees" Order Form**

Please send me ..... copies of the above free pamphlet.

Name.....

Address.....

I am in Solo ..... Group ..... practice.

Send. to:

Public Relations and Economics Division  
Illinois State Medical Society  
360 N. Michigan Ave.  
Chicago, Ill. 60601



## Forming An I. M. A. A. County Chapter

BY MRS. LINDA SMITH/DANVILLE

Perhaps many of you have not heard of our organization—The Illinois Medical Assistants Association—or have heard of it but were unaware that you could be instrumental in forming a chapter in your county for your medical assistants. We are an organization of receptionists, secretaries, bookkeepers, nurses, technicians and assistants employed in offices of doctors of medicine or hospitals. I.M.A.A. objectives are to inspire its members to render honest, loyal and more efficient service to the profession and to the public which they serve; to strive at all times to cooperate with the medical profession in improving public relations; to render educational service for the self-improvement of its members; to stimulate a feeling of fellowship and cooperation among the societies.

In forming a chapter within your county, several procedures are required. First, you contact the I.M.A.A. Membership Committee. The Vice Presidents of I.M.A.A., Mrs. Vivian Johnson (9105 S. Albany Avenue, Evergreen Park, Illinois 60642) and Mrs. Mary Siers (801 N. 84th Street, East St. Louis, Illinois 62203) are Co-Chairmen of this committee and provide counties interested in forming chapters with literature and know-how in contacting each and every Medical Assistant in the area who share an interest in being a part of the Association.

Second, approval from the County Medical Society is necessary before a chapter may be formed. After the county society understands that we are NOT a union with any thoughts of unionizing all the medical

assistants, approval is readily given. Our constitution specifically states—"This association is hereby declared to be non-profit. It is not, nor shall it ever become, a trade union or collective bargaining agency."

Third, if you have approximately 10 interested Medical Assistants in your area, an informal meeting can be arranged so that temporary officers can be elected to get the ground work started. The IMAA Membership Committee along with the other state officers will be happy to attend your informal meeting to help you get started and answer any questions regarding I.M.A.A. A minimum membership of 10 is required in order for a chapter to receive a charter. Once the chapter is organized, its potential growth is virtually unlimited.

Perhaps you live in a rural area where there are not many Medical Assistants. This does not mean your assistant cannot belong. We have at-large members from many areas of the state. These persons enjoy many of the privileges of membership—receiving copies of the publications from I.M.A.A. and the American Association of Medical Assistants, attending the educational symposium held each September and the annual convention in April.

Are you wondering—Why should a Medical Assistant be part of this organization? Here are a few of the many reasons. Opportunity for continued education; affiliation with others engaged in the same profession; comprehensive group insurance program with salary replacement, major hospital, medical and surgical coverage;



assured friendship; fellowship extended beyond your city to include any city with an established chapter of I.M.A.A. or A.A.M.A.

Component chapter meetings are held once a month from September through May. Programs of an educational nature are arranged using films (many are available from the pharmaceutical companies, A.M.A., A.A.M.A., and I.S.M.S.) or speakers chosen because of their particular field of endeavor in allied health careers. We encourage education of our members to become Certified Medical Assistants by giving them suggestions for study groups and outlines for study.

Doctors, the Illinois Medical Assistants Association wants your Medical Assistant to be a part of our Association. There are many benefits she will gain from membership and we know we will gain by having her with us. Each new member gives us insight as to how best to serve you.

We want our organization to be directed by medical assistants, for all medical assistants, and to have growth throughout the entire state of Illinois. The formation of a new chapter is not hard and we are always ready to help. Please contact Mrs. Johnson or Mrs. Siers for more information.

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## ***Looking for a Place to Practice? Placement Service Lists Openings***

In an effort to reduce the number of towns in Illinois needing practicing physicians, the *Journal* is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

**WHITESIDE COUNTY:** Tampico; population: 800. Trade area: 5,000. Previous physician had been here 30 years. Equipped office available if desired. Nearest hospital at Sterling, 15 miles. Nearest physician, 12 miles. Grade and high schools. Protestant and Catholic churches. Three country clubs within 15 miles. Active Lions Club, Masonic Lodge, Eastern Star, Civic League, PTA, etc. For further information contact: Earl R. Krantz, Box 13, Tampico; Phone 438-2433, or Tampico Barber Shop, Box 246, Tampico; Phone: 438-2715.

**WILL COUNTY:** Plainfield; population: 2,600. Trade area: 4,000. Two physicians. Nearest hospitals at Joliet, 8 miles. Present physicians prefer to have an additional one, solo or associate. Office space includes 4

exam rooms, lab, business office, consultation room. Ample parking. Five hundred hospital beds in Joliet. Industry and agriculture. Congregational, Catholic, Methodist, Lutheran and Baptist churches. Grade and high schools. Six golf courses within 20 miles. Conveniently located to Chicago. For further information contact: F. C. Bener, M.D., 104 S. Joliet Rd., Plainfield. **WILL COUNTY:** Wilmington; population: 4,450. Trade area: 12,000. Three physicians, all over 40. Nearest hospitals at Joliet, 19 miles, and Kankakee, 22 miles. Population of Joliet, 77,000. Two local drug stores. Grade and high schools. Catholic and Protestant churches. Sixty miles from Chicago on expressways. Excellent recreational facilities. Two of the 3 physicians in poor health. No information available as to office space. For further information contact: Charles Wilson, M.D., 5816 First Ave. Dr., N.W., Bradenton, Florida. (Practiced here before retirement.)

**WOODFORD COUNTY:** Roanoke; population: 2,000. Trade area: 4,000. One physician, age 68. Second moved due to disability. Nearest hospital at Eureka, 9 miles. Twenty-five miles east of Peoria. Office space available. Financial assistance if desired. Sources of income: agriculture and several small industries. Five Catholic and Protestant churches. Grade and high schools. New park. Plans for pool in near future. Golf courses within 12 miles. For further information contact: Williard J. Sauder, President, Peoples State Bank of Roanoke, Roanoke 61561.













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